

# Bundle Quality, Safety & Experience Committee 4 May 2021

9.30am PUBLIC Session

Via Microsoft Teams

- 1.0 OPENING BUSINESS AND EFFECTIVE GOVERNANCE
- 1.1 09:30 - QS21/58 Chair's Opening Remarks  
*Welcome Audit Wales observer Urvisha Perez*
- 1.2 09:32 - QS21/59 Declarations of Interest
- 1.3 09:33 - QS21/60 Apologies for Absence
- 1.4 09:34 - QS21/61 Minutes of Previous Meeting Held in Public on 2.3.21 for Accuracy, Matters Arising and Review of Summary Action Log  
QS21.61a Minutes QSE 2.3.21 Public V0.02.docx  
QS21.61b Summary Action Log QSE Public.docx
- 1.5 09:49 - QS21/62 Patient Story : Matt Joyes  
*Recommendation:*  
*The Quality, Safety and Experience Committee is asked to receive and reflect upon the patient story.*  
  
*Note:*  
*Arrangements are being made for non-BCU attendees to be able to listen to the audio clip linked in the paper*  
QS21.62 Patient Story\_final.docx
- 2.0 FOR DISCUSSION
- 2.1 Covid-19 Matters
- 2.1.1 09:59 - QS21/63 Ysbyty Gwynedd Outbreak - Gill Harris  
*Representatives of Hospital Management Team to attend (Karen Mottart, Barry Williams, Mandy Jones, Adrian Butlin, Georgina Roberts, Lesley Walsh)*  
QS21.63 YG outbreak presentation v0.4 210421.pptx
- 2.1.2 10:29 - QS21/64 Covid Update - Gill Harris / Chris Stockport  
*Recommendation:*  
*The Committee is requested to note the position outlined in this report and provide comments on progress of the programmes.*  
QS21.64 Covid-19 update v3.docx
- 2.2 10:44 - QS21/65 Mental Health and Learning Disabilities Division receipt of and actions from the "Review of the Discharge of Mental Health Patients During the Covid-19 Pandemic" - Teresa Owen  
*Recommendations:*  
*The Committee is asked to note:-*  
*1. That the division fully accepts both the findings and recommendations of the report*  
*2. That the division has considered and stated its learning from the report*  
*3. That the division has stated its actions to prevent recurrence both tactically and strategically as it plans its next steps.*  
QS21.65 Mental Health Primary Care discharge Report V2.1 final.docx
- 2.3 10:54 - QS21/66 Mental Health and Learning Disabilities Exception Report - Teresa Owen  
*Recommendation:*  
*The Committee is asked to note the update from the Mental Health & Learning Disabilities Division.*  
QS21.66 MHLDD v1.0 FINAL.doc
- 2.4 11:04 - QS21/67 Quality Governance Review : Ysbyty Glan Clwyd - Gill Harris  
*Recommendation:*  
*The Quality, Safety and Experience Committee is asked to receive this report for assurance.*  
QS21.67a QGR Report YGC Final.docx
- 2.4.1 11:19 - COMFORT BREAK
- 2.5 11:29 - QS21/68 Healthcare Inspectorate Wales Update - Gill Harris  
*Recommendation:*  
*The Quality, Safety and Experience Committee is asked to receive this report for assurance.*  
QS21.68 HIW Update Paper.docx
- 2.6 11:44 - QS21/69 Healthcare Inspectorate Wales Maternity Review : BCU Action Plan - Gill Harris  
*Recommendation:*  
*The Quality, Safety and Experience Committee is asked to receive this report for assurance.*  
QS21.69a HIW Maternity Review.docx

- 2.7 11:54 - QS21/70 Quality Governance Self Assessment Action Plan (Maternity Services) - Gill Harris  
*Recommendation:*  
*The Committee is asked to note the report and update of the Quality Governance Self-Assessment Action Plan.*  
QS21.70a Quality Governance Review\_Maternity Self-assessment report\_final.docx  
QS21.70b Quality Governance Review\_Maternity Self-assessment Action Plan\_Appendix 1.docx
- 2.8 12:04 - QS21/71 Patient and Carer Experience Q4 Report - Gill Harris  
*Recommendation:*  
*The Committee is requested to note the ongoing planned improvement work, including review of various Health Board processes.*  
QS21.71 Patient Carer Experience Q4 Report\_final.docx
- 2.9 12:19 - QS21/72 Patient Safety Q4 Report - Matt Joyes  
*Recommendations:*  
*The Quality, Safety and Experience Committee is asked to:*  
*1. Note the report.*  
*2. Note the focus on improving learning, reducing incidents resulting in avoidable harm and the evolving improvement of assurance in this area recognising significant work remains.*  
*3. Note the delay of the Once for Wales Concerns Management System.*  
*4. Receive this report and provide feedback on its evolving content and layout.*  
QS21.72 Patient Safety Q4 Report\_final.docx
- 2.10 QS21/73 Quality & Performance Report - Kamala Williams  
*Recommendation:*  
*The Committee is asked to note the report*  
QS21.73a QaPR report template March 2021\_FINAL.docx  
QS21.73b QaPR March 2021\_FINAL.pdf
- 2.11 12:29 - Item deferred
- 2.12 12:39 - QS21/75 Board Assurance Framework and Corporate Risk Register - Louise Brereton and Simon Evans-Evans  
*Recommendation:*  
*That the Committee:-*  
*(1) review and note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF);*  
*(2) review and note the progress on the Corporate Tier 1 Operational Risk Report.*  
*i) approve the completion of CRR20-01 actions so they can be archived and removed from the next report*  
*ii) approve the reduction of score in CRR10-01 in line with completed actions to support the mitigation of the risk.*  
  
*Dawn Sharp to attend*  
QS21.75a BAF and CRR cover report-V1.02 updated 27.4.21.docx  
QS21.75b BAF Appendix 1 version 2 final.pdf  
QS21.75c BAF and CRR Appendix 2.docx  
QS21.75d BAF and CRR Appendices 3a and 3b - Corporate Tier 1 Operational Risk Report-V1.pdf
- 2.13 12:59 - QS21/76 Annual Assurance Report on compliance with Nurse Staffing Levels (Wales) Act 2016- Gill Harris  
*Recommendations:*  
*1. The Committee are asked to note and support the following next steps which are incorporated into the overall Health Board recruitment and retention programme :*  
*a. Targeted focus of innovative Nurse recruitment campaigns both locally, nationally and internationally*  
*b. Succession planning for the future, ensuring we are developing our next generation leaders*  
*c. Creatively co-designing our post graduate programmes as key attractors*  
*d. Analysing workforce data to better inform Nurse recruitment and retention initiatives*  
*e. Review of implementation of new roles to support the nursing recruitment pipelines*  
*f. Expansion of quality improvement driven collaborates to assist in reducing variation and harm reduction with a zero tolerance approach*  
*g. Development of a Nurse performance dashboard as a further monitoring and assurance tool in real time*  
*h. Further analysis of deviations from previous reporting periods and analysis of the first triennial reporting period of the Act*  
*2. Sharing the outputs of the Nurse Staffing reviews with the Finance and Performance Committee to support changes to the Nurse staffing establishments as presented*  
QS21.76a Nurse Staffing report\_final.docx  
QS21.76b Nurse Staffing Appendix 1 Annual Assurance Report May 2021.docx  
QS21.76c Nurse Staffing Appendix 2 Three Year Assurance Report May 2021.docx

[QS21.76d Nurse Staffing Appendix 3 CNO Letter - clarity on C19 disruption to Nurse Staffing Levels \(Wales\) Act.pdf](#)

[QS21.76e Nurse Staffing Appendix 4 CNO Letter - extension of second duty to paediatric in-patients.pdf](#)

[QS21.76f Nurse Staffing Appendix 5 CNO Letter - update on Covid19 disruption to Nurse Staffing Levels \(Wales\) Act 2016.pdf](#)

[QS21.76g Nurse Staffing Appendix 6 Joint statement issued by CNO - Professional bodies.pdf](#)

[QS21.76h Nurse Staffing Appendix 7 Establishment Outputs.docx](#)

3.0 13:14 - FOR CONSENT

3.1 QS21/77 Patient Safety Quality Group : Chair's Triple A Report - Gill Harris

*Note - Other sub-groups have not met since their last report to the QSE Committee.*

[QS21.77 PSQ Chair Report.docx](#)

3.2 QS21/78 Antimicrobial Prescribing Policy

*Substantial review so changes have not been tracked. Policy has been agreed at Antimicrobial Steering Group; Medicines Policies and Procedures Group; Drug and Therapeutics Group and the former Quality Safety Group.*

[QS21.78a Antimicrobial Prescribing Policy v5.docx](#)

[QS21.78b Antimicrobial Prescribing Policy Equality Impact Assessment Screening Sept 2020 MM10 v0.4.docx](#)

3.3 QS21/79 Committee Annual Report 2020-21 - Gill Harris

*Recommendations:*

*The Committee is asked to:*

- 1\ Review the draft Annual Report for 2020\-21
- 2\ Provide comments and feedback as necessary
- 3\ Agree that Chair's Action can be taken if necessary before submission to Audit Committee

[QS21.79a Committee Annual Report\\_front template.docx](#)

[QS21.79b QSE Committee Annual Report 2020-21 V0.4.docx](#)

[QS21.79c Committee Annual Report QSE ToR V6.0.pdf](#)

4.0 13:24 - FOR INFORMATION

4.1 QS21/80 Issues Discussed in Previous Private Session

*Recommendation:*

*The Committee is asked to note the report*

[QS21.80 Issues discussed in previous private session.docx](#)

4.2 QS21/81 Documents Circulated to Members

*25.2.21 Operational Plan Monitoring Report and Quality Performance Report*

*13.4.21 Internal Audit Limited Assurance Report - MH&LD Governance Arrangements*

4.3 QS21/82 Board of Community Health Councils in Wales "Feeling Forgotten?" Report

[QS21.82 Feeling forgotten - waiting for care and treatment during the coronavirus pandemic.pdf](#)

4.4 QS21/83 Issues of Significance to inform the Chair's Assurance Report

4.5 QS21/84 Date of Next Meeting

6.7.21

4.6 QS21/85 Exclusion of Press and Public

*Resolution to Exclude the Press and Public - "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."*

4.7 13:29 - Lunch break



**Quality, Safety and Experience (QSE) Committee**  
**Minutes of the Meeting Held in public on 2.3.21 via Zoom**

**Present:**

Lucy Reid	Independent Member (Chair)
Jackie Hughes	Independent Member
Cheryl Carlisle	Independent Member
Lyn Meadows	Independent Member

**In Attendance:**

Jackie Allen	Chair of Community Health Council (CHC) ( <i>part meeting : not recorded</i> )
Louise Brereton	Board Secretary ( <i>part meeting</i> )
Kate Dunn	Head of Corporate Affairs ( <i>for minutes</i> )
Gareth Evans	Chair of Healthcare Professional Forum
Simon Evans-Evans	Interim Director of Governance ( <i>part meeting</i> )
Jo Garzoni	Vascular Network Manager ( <i>part meeting</i> )
Andrew Gralton	Assistant Director Children and Young People's Services – East ( <i>part meeting</i> )
Sue Green	Executive Director of Workforce and Organisational Development (OD)
Arpan Guha	Interim Executive Medical Director
Dave Harries	Head of Internal Audit
Gill Harris	Executive Director of Nursing and Midwifery / Deputy Chief Executive ( <i>part meeting</i> )
Sue Hill	Executive Director of Finance ( <i>observing part meeting</i> )
Bethan Jones	Area Director - Central ( <i>part meeting</i> )
Matthew Joyes	Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience
Andrew Kent	Interim Head of Planned Care Transformation ( <i>part meeting</i> )
Jon Lloyd	Interim Head of Performance
Melanie Maxwell	Senior Associate Medical Director/Improvement Cymru Clinical Lead
Teresa Owen	Executive Director of Public Health ( <i>part meeting</i> )
Dawn Sharp	Deputy Board Secretary ( <i>part meeting</i> )
Soroush Sohrabi	Vascular Consultant ( <i>part meeting</i> )
Chris Stockport	Executive Director Primary and Community Services
Adrian Thomas	Executive Director Therapies and Health Sciences
Jo Whitehead	Chief Executive ( <i>part meeting</i> )

**AGENDA ITEM DISCUSSED****ACTION BY****QS21/34 Chair's Opening Remarks**

**QS21/34.1** The Chair welcomed everyone to the meeting and confirmed that the agenda was again more focused as a result of ongoing pandemic challenges.



<p><b>QS21/35 Declarations of Interest</b></p> <p><b>QS21/35.1</b> Gareth Evans declared an interest in the vascular agenda item due to his substantive role within the Health Board.</p>	
<p><b>QS21/36 Apologies for Absence</b></p> <p><b>QS21/36.1</b> It was noted that various officers would need to leave the meeting early. Mike Smith had tried to join the meeting but experienced technical difficulties and submitted his apologies via email.</p>	
<p><b>QS21/37 Minutes of Previous Meeting Held in Public on 15.1.21 for Accuracy, Matters Arising and Review of Summary Action Log</b></p> <p><b>QS21/37.1</b> The minutes were agreed as an accurate record pending the correction of job titles for Debra Hickman and Matt Joyes.</p> <p><b>QS21/37.2</b> Updates were provided to the summary action log.</p>	
<p><b>QS21/38 Covid-19 Vaccination Update</b></p> <p><b>QS21/38.1</b> The Chair wished to record that Board members received regular written updates on progress on the vaccination programme and there were also weekly Covid Board Briefings.</p> <p><b>QS21/38.2</b> The Executive Director of Nursing and Midwifery reported that there was positive progress with the vaccination programme with the current focus on delivering the second doses of the Pfizer vaccine and ensuring nobody was left behind within cohorts 1-4. Primary care were making good strides in progressing cohorts 5 and 6. Conversations were ongoing with partners via the Gold vaccination group to finalise the Vaccination Plan and a final draft was expected within a week. She also acknowledged the support from Local Authority partners to the work around hard to reach groups. <i>[Dawn Sharp joined the meeting]</i> Members' attention was drawn to significant progress with the establishment of the call centre, strengthening of infrastructure and the piloting of new technology.</p> <p><b>QS21/38.3</b> Members acknowledged the hard work being undertaken in delivering the vaccination programme and expressed their thanks to all involved. A comment was made that whilst appreciating the need to follow the guidelines for priority of cohorts, the vaccination of carers would be welcomed. A member referred to a cohort of patients who were not registered with a GP and the Executive Director of Nursing and Midwifery confirmed this group had been flagged and identified.</p> <p><b>QS21.38.4 It was resolved that the Committee:</b></p> <ol style="list-style-type: none"> <li>1. Note the current vaccination number to date</li> <li>2. Note the high ranking risks to the programme</li> <li>3. Recognise the successful completion of gateway 1 the achievement of cohort 1-4 at above 80%</li> </ol>	

## **QS21/39 Board Assurance Framework (BAF) Principal and Corporate Risk Report (CRR)**

**QS21/39.1** The Deputy Board Secretary introduced the documentation and confirmed that the refreshed approach to risk management had been signed off by the Health Board in January 2021 and subsequently there had been meetings with respective leads to support them in reviewing and updating each risk.

**QS21/39.2** The Chair invited general comments before detailed questions on the individual risks. The Chair of the Strategy, Partnerships and Population Health (SPPH) Committee confirmed that an equivalent paper had been received at SPPH on the 23.2.21 and observations there had included a request for a key against the assurances, concern at the lack of clarity around the risk appetite and that mitigating actions needed to be more robust. The SPPH Committee had stated that the decision to review the risk appetite should be taken at Board level rather than individual committees. The Interim Director of Governance indicated that the key for BAF assurances was included within the front narrative paper. He also confirmed that risk appetite would be considered by the Board at a Workshop in April. The Chair suggested that the BAF and the CRR should be presented as two separate agenda items. The Interim Director of Governance undertook to look at this possibility but noted that the single report had been developed with the aim of demonstrating the interdependencies. The Chair also noted with disappointment some incomplete sentences, confusing terminology and inaccurate references (eg to the Quality and Safety Executive).

SEE/LB

**QS21/39.3** The Chair then invited questions or comments on the BAF risks (Appendix 1):

- The progress in the development of a BAF as part of wider governance framework was acknowledged.
- BAF20-06 (pandemic management) – it was suggested some key controls were missing, for example the reporting against quality indicators to the QSE Committee.
- BAF20-08 (mental health services) – it was felt that the leadership team reporting into the Executive Team was an assurance process rather than a key control for the delivery of safe services as stated. In addition, the learning aspect needed to be more visible.
- BAF20-11 (infection prevention and control) – it was suggested that key controls were missing, for example surveillance, audit, learning from the action plan of the Wrexham outbreak.
- BAF20-13 (culture / staff engagement) – the point was made that reference to policies as key controls was inappropriate as whilst they may contribute to responding to a risk, their mere existence wasn't a key control. The Executive Director of Workforce and OD accepted the comment but felt the narrative reflected the situation previously which had prompted the review.

TO/LB

GH/LB

**QS21/39.4** The Chair then invited questions or comments on the CRR risks (Appendix 2):

- CRR20-04 (non-compliance of fire safety systems) – it was asked whether this risk had also been flagged to the Finance and Performance (F&P) Committee and this was confirmed.
- CRR20-08 (clinical capacity relating to vision loss) – a member enquired as to the intended timeframe in achieving the target risk score of 6 from the current risk rating of 20. The Executive Director of Nursing and Midwifery suggested the timeline would need to

reflect the insourcing plans and she would ask the team to confirm their ambition for demonstrating improvement. A member felt that as the actions were given a RAG status of “on track” it was of concern that the current risk remained at 20. The Chair also felt that both of the actions related to the development of business cases which in themselves would not address the risk. The Executive Director of Nursing and Midwifery indicated there had been a conversation at the F&P Committee regarding the cross-over on this risk and she suggested that a meeting be arranged between herself, the QSE Chair, The Executive Director of Planning and Performance and the Executive Director of Finance to work this through. The Chief Executive added that whilst duplication was not ideal, one Committee could take assurance from another Committee’s assurances.

GH

LB

**QS21/39.5** The Chair then asked members to consider the three operational risks highlighted for escalation. Members supported the inclusion of CRR20-08 (ophthalmology). In terms of CRR20-09 (diabetes) the Chair expressed concern that this had been scored at the highest level however it would appear to have been created and scored on the basis of the situation pertaining to a single clinical post which had already been out for advert. She confirmed that the Committee did not approve the decision to escalate CRR20-09 onto the Corporate Risk Register as requested. The Chief Executive accepted this would need further review. With regards to CRR20-10 (GP Out of Hours) it was noted this was information and the assuring Committee would be the Digital and Information Governance Committee. The Chair raised a point of clarity in terms of consistency with the Risk Management Strategy and the role of the Board Committees which would be picked up outside.

JW/SEE

SEE

**QS21/39.6 It was resolved that** the Committee:

1. Review and note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF) and Corporate Tier 1 Operational risks presented.
2. That the review of the Risk Appetite Statement in the light of some of the existing target risk scores needed to be considered by the Board as a whole.

*[Sue Hill and Dawn Sharp left the meeting]*

#### **QS21/40 Infection Prevention & Control (IPC) Report**

**QS21/40.1** The Executive Director of Nursing and Midwifery presented the report and highlighted key messages as being - 1) the work that was being implemented to strengthen IPC and to get back to a zero tolerance position for Healthcare Acquired Infections (HCAs), with additional communications support now having been secured to reinvigorate that campaign; 2) a decision to appoint an external individual to undertake a table top review of the outbreak in Ysbyty Gwynedd (YG) against the Wrexham Maelor Hospital (WMH) action plan; 3) the need to be consistent and robust with the message that IPC is everybody’s business and actions will need to be long-term.

**QS21/40.2** The Chief Executive indicated that she had visited the YG site on the 1.3.31 and met with a range of clinicians and ward staff. She came away with an overwhelming observation around the strength of leadership and tangible personal support to staff. There was a high level of confidence that the actions put in place since the outbreak would bear fruit but that there would be a need to look at the human behavioural factors using the learning from Wrexham. The Executive Director of Nursing and Midwifery wished to personally

acknowledge and apologise for the harm that had been caused as a result of the outbreak, and also to commend all the staff who continued to work so very hard in very difficult circumstances.

**QS21/40.3** A member noted an increase in c.difficile cases and the Executive Director of Nursing and Midwifery acknowledged that this was likely due to antimicrobial stewardship not being monitored as closely as it could have been whilst efforts were understandably being focused on Covid measures. A comment was made that the IPC Strategy needed to sustain progress where it had been made, and to require new actions to make a difference. Finally it was suggested that the narrative in the paper could set out links with the mortality paper more clearer in terms of IPC within a community and primary care setting.

**QS21/40.4** It was resolved that the Committee take assurance from the Infection Prevention presentation this month.

*[Bethan Jones and Andrew Gralton joined the meeting]*

#### **QS21/41 Health & Safety Update Report Covid19**

**QS21/41.1** The Executive Director of Workforce and OD presented the report and clarified that whilst there were other health and safety risks, this particular paper focused on Covid related matters. She confirmed that sadly a further member of staff had been lost as a result of Covid within the last week, taking the total to four. One of the deaths was subject to Health and Safety Executive (HSE) investigation but the Board had been informed there was not going to be an associated prosecution. The organisation was required to make improvements and currently these were being tested to determine how well they had been embedded. The Executive Director of Workforce and OD then went on to confirm that actions as a result of the recent HSE improvement notice had now been completed and evidence submitted to HSE. She also drew members' attention to performance in terms of staff Covid vaccinations with a revised timeframe for all second doses within cohorts 1-4 by the 17.3.21. In addition a cohort of staff who didn't receive their first dose was now being worked through. She concluded by advising that the significance of new and emerging variants should not be underestimated.

**QS21/41.2** A member referred to the statement that 700 staff Covid cases had been reported under RIDDOR and enquired if there was a breakdown of this data which could help identify patterns – for example whether certain cohorts of staff were more susceptible. The Executive Director of Workforce and OD confirmed that a demographic breakdown including socio economic factors and ethnicity could be built into the next report. A member wished to highlight the hard work undertaken by the Fit Testing teams and that this data had now been added to ESR (electronic staff record). The Chair referred to the 'Make It Safe' reviews and suggested that themes with remedial action should be more visible in future reports.

**QS21/41.3** It was resolved that the Committee note the position outlined in the report.

*[Teresa Owen left the meeting. Sue Hill rejoined the meeting]*

#### **QS21/42 The Impact of Covid-19 on Child Health Services within BCUHB**

*[Bethan Jones and Andrew Gralton joined the meeting]*

SG

SG

**QS21/42.1** The Area Director presented the report which detailed that whilst children had been less affected by Covid as a disease, there were clear concerns at the impact and consequences of Covid and the pandemic on children and young people. She highlighted that normal pathways had been interrupted and networks such as school and social activities paused. She stated that partnership working had been vital throughout the pandemic and this had been positive and encouraging. It was noted that some non-urgent services were stood down at the start of the pandemic but on a prioritised basis, and the report set out a summary against each of the key services areas and identified the impact of Covid upon them. The Area Director confirmed that generally referrals into children's services had reduced and there was a concern that some things could have been missed during the pandemic. Referrals into CAMHS (Child Adolescent Mental Health Service) had also reduced and there would have been lost contact opportunities whilst Health Visitor visits into families' homes had been paused or reduced. In addition she noted that neurodevelopment assessments had been heavily affected by lockdown. The Area Director concluded that the full impact of Covid on children's services would not be fully understood for some time.

**QS21/42.2** A member expressed concern at the need to recommence face to face care particularly for neurodevelopment assessment. The Assistant Director Children and Young People's Services assured the Committee that every referred child was individually risk assessed and if it was determined they needed a face to face assessment they would be offered this. For neurodevelopment assessments these were being carried out remotely with a new tool being developed. He recognised that the suspension in services, combined with a loss of capacity to ensure that social distancing requirements could be met, had impacted adversely across children's services and would need to be recovered. A member also noted a concern for parents and young carers who were struggling without the usual levels of support, and she felt there may be a need to increase safeguarding capacity once services opened up more widely. Finally she enquired around children and young people who had been placed out of area. The Assistant Director Children and Young People's Services responded that each child placed out of area had a nominated case co-ordinator and he could provide information outside of the meeting on the numbers that were either being seen face to face or remotely.

**QS21/42.3** The Chair felt that the report was helpful and clearly set out identified risks and how they were being mitigated. The Executive Director of Primary and Community Services acknowledged with respect how the teams had managed to think creatively in order to keep services running in very difficult circumstances. The Area Director added that funding had been secured for the use of Information Technology within community children's services which she hoped would allow services such as Health Visiting to keep pace with modern practices that were in operation in other services.

**QS21/42.4** It was resolved that the QSE Committee endorse the report

*[Louise Brereton and Simon Evans-Evans left the meeting]*

**QS21/44 Covid-19 Mortality Report**

A  
Gralton

**QS21/44.1** The Senior Associate Medical Director presented the paper which provided an overview of deaths where Covid-19 was a direct or contributory factor. She highlighted that BCUHB had experienced 562 excess deaths which was 7.5% more than expected compared to the previous three years. This figure was less than seen in other Health Board areas due to Covid-19 surge being experienced later in the North than the rest of Wales. Data indicated that the increase in mortality was predominantly related to Covid-19 with the peak of the current (second) surge being more severe than the first, however, the first surge was more sustained. The Senior Associate Medical Director referred to epidemiology activity based on Public Health Wales (PHW) data which demonstrated a national pattern that the further away an individual was from a positive Covid-19 test, the less likely it was that Covid-19 would be the cause of death. Overall there was however a higher proportion of Covid-19 having contributed to the number of excess deaths, combined with higher fragility levels and other underlying factors. In BCUHB the largest number had been seen in the East where stage 1 reviews were still ongoing. In the Centre, Ysbyty Glan Clwyd (YGC) was going through the medical examiner process and looking at the referrals so far there had not been significant concerns over the medical care of the patient. In terms of HCAs the Senior Associate Medical Director confirmed that there was some data from cluster analysis and that post infection reviews always took place with immediate actions around increased cleaning and the use of Personal Protective Equipment (PPE). The reviews focused on patient outcomes and learning from one site was shared more widely with a clear message that embedding a consistent approach was essential.

**QS21/44.2** In response to a question regarding gaps in data for community sites the Senior Associate Medical Director confirmed that any death relating to an in-patient bed in the community setting was still recorded by the Health Board, however, there were differences in how the death certificate was completed. A comment was made that the presentation of the figures on deceased patients with HCAs was difficult to follow by the reader. The Senior Associate Medical Director stated that it was hoped to be able to include community deaths from HCAs in the future. A member noted with disappointment that the basics of effective use of PPE, hand washing and social distancing were still proving challenging in some areas and sites 12 months on into the pandemic, and that this was reiterated in other papers. She also referred to the findings of the Post Infection Reviews (PIRs) and suggested that the reporting of non-closing bay doors would not address the core issue and that the narrative could be stronger. In response to a question regarding the involvement of Health and Safety teams, the Senior Associate Medical Director confirmed that site Hospital Directors were involved in discussions across a range of teams to build on triangulating the totality of information coming out of the PIRs. A member referred to the role of Medical Examiners and whether they had all the information they needed. The Senior Associate Medical Director clarified that the Medical Examiners considered whether the clinical care received had been appropriate and it was not their role to look at environmental aspects. The Chair welcomed the inclusion of positive findings as learning points in the paper and felt this was often overlooked. She noted that there were recurring themes evident across a number of the reports which emphasised the need for organisational learning to be fully embedded across the HB. The Chair referred to the action plan provided and observed that the findings and subsequent actions did not consider the human factors and it was difficult to determine how

the actions would address the findings. She suggested a conversation outside of the meeting may be helpful in terms of content and presentation.

MM

**QS21/44.3** It was resolved that the Committee review the report that documented deaths from COVID 19, findings from reviews undertaken and the associated learning.

**QS21/46 Update on Planned Care Recovery and Essential Service Delivery Within Planned Care**

*[Andrew Kent joined the meeting. Agenda item taken out of order at Chair's discretion]*

**QS21/46.1** The Interim Director of Planned Care Transformation presented the paper which built upon previous updates on the quality and safety of planned care during the pandemic and the focus on the six point plan. In terms of a performance perspective across Wales, it was reported that BCUHB had the strongest 62 day cancer performance. The Interim Director of Planned Care Transformation confirmed that since writing there had been a declared outbreak in the West. Services had been paused and a "Once for North Wales" approach was being taken to move P2 risk stratified patients and services to the safest site in terms of Covid-19, including on occasions moving the surgeon to another site. Other categories of patients such as upper gastro-intestinal and urology could not currently be moved. The Planned Care Transformation Group (PCTG) were overseeing moving patients from West to East with Centre on standby to support. The challenge was that when patients were previously moved East to West, YG had all facilities running, whereas this was no longer the case. The Committee were informed that full Multi Disciplinary Team assessments were in place with each patient being risk stratified. In terms of insourcing, it was reported that ophthalmology at YG could continue as was a completely separate unit to the main site affected by the outbreak. A tender waiver had been developed by the insourcing group but the challenge in remaining Covid-safe meant it took longer to arrange capacity and get assurances from insourcing companies. The Interim Director of Planned Care Transformation confirmed there would be a blended workforce model of BCUHB consultants supported by insourced staff, and that the overall recovery programme could take up to three years with long waiters being treated when safe to do so.

**QS21/46.2** A member referred to the single tender waiver for insourcing and asked whether there was a feeling around the quantum of patients that could be treated and whether there was an associated communications package. The Interim Director of Planned Care Transformation confirmed that a non-activity tender had been chosen so the anticipated numbers were not known. In terms of communications, he confirmed there would be a related launch and there were other plans in place such as a patient portal and an Escape from Pain Programme, but these had not broadly been advertised.

**QS21/46.3** The Chair recalled the Committee's comments at the January meeting that the richness of the narrative in presenting the paper provided more assurances than the paper itself and was disappointed that this was again the case. She reiterated that whilst the F&P Committee would be interested in the numbers from a performance perspective, the QSE Committee should be able to focus on aspects of patient safety and potential harm and what was being done to address this. She felt this did not come through strongly enough within the

paper. The Interim Director of Planned Care Transformation would reflect on these expectations ahead of the production of the next paper to the Committee.

AK

**QS21/46.4 It was resolved that** the Committee note the approach that is part of the six-point plan and its link to maintaining patient safety and quality

### **QS21/45 Patient Safety Report Q3**

**QS21/45.1** The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience presented the paper which provided information and analysis on significant patient safety issues arising during Quarter 3 together with longer-term trend data, and information on the safety improvements underway. He wished to highlight that the Falls Improvement Group had met recently for the first time in a while and that BCUHB continued to report a number of falls resulting in serious harm. He also highlighted there continued to be avoidable Hospital Acquired Pressure Ulcers (HAPUs).

**QS21/45.2** Moving onto Never Events it was reported there had been one new Never Event within the quarter relating to a medication issue at YGC. The investigation was ongoing but there was early learning emerging around guidance and information given to patients at point of discharge and process issues when changing quantities. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience added there was a recurring theme in Never Events around surgical safety and the appropriate use of checklists, which was being reviewed with the relevant teams.

**QS21/45.3** With regards to Inquests it was noted that the Coroner had deferred a number during the pandemic which had resulted in a significant number now having accumulated. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience was keen to take these forward, recognising the impact of further delays on grieving families. He highlighted a new Coroner had been appointed in the West area. A question was raised that the figures did not tally on page 10 and this would be looked into outside of the meeting.

MJ

**QS21/45.4** The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience drew members' attention to the Welsh Risk Pool review into the Emergency Department at YGC which identified a number of governance deficiencies that had resulted in a suspension of reimbursements until it had been addressed. He stated that the new clinical lead had taken on the associated improvement work resulting from this review.

**QS21/45.5** It was reported that there was 1 patient safety alert overdue since 2017 which related to national surgical safety standards and that following conclusion of work being undertaken within secondary care it was hoped this could be closed by April. An update to Datix was planned for launch from 1.4.21 which would hopefully improve functionality for reporting against patient safety alerts. The Chair welcomed this and felt it could be a positive step towards supporting better thematic reporting and aiding learning.

*[Gill Harris left the meeting]*

**QS21/45.6** The Chair reiterated her wish to see a golden thread throughout future patient safety reports with each quarterly report following on from the previous as incidents and



events would span multiple quarters. She added that the delay with the open safety alert was unacceptable. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience accepted these comments.

**QS21/45.7 It was resolved that the Committee:**

1. Note the concerns about the introduction of the Once for Wales Concerns Management System incidents module.
2. Receive the report and provide feedback on its evolving content and layout.

**QS21/47 Vascular Task and Finish Group Update**

*[Jo Garzoni (Vascular Network Manager) and Soroush Sohrabi (Vascular Consultant) joined the meeting]*

**QS21/47.1** The Executive Medical Director presented the paper which provided an update on the work of the Vascular Task and Finish (T&F) Group. He wished to highlight three key elements – pathways, engagement and safety issues. Firstly, he confirmed that much of the pathway work was well progressed with some having been approved recently at the Clinical Advisory Group. The pathway with work still to do was the diabetic foot care pathway which required a true multidisciplinary approach. An update on progress would be made to the next meeting of the T&F Group on the 18.3.21. With regards to engagement the Executive Medical Director acknowledged the helpful representation to the T&F Group by CHC colleagues and their support in enabling elements of patient information to be approved. Finally, in terms of safety, quality and clinical effectiveness the Executive Medical Director indicated that the National Vascular Registry results showed that BCUHB was performing above the national average although was an outlier in terms of amputations. He stated that he had requested an internal multidisciplinary review of all deaths which did not note anything untoward, however, the findings of an external review from the Royal College was awaited.

**QS21/47.2** A member queried why an additional 8 beds were needed so soon after the agreement of the original business case. The Vascular Network Manager confirmed the role of the T&F Group to revisit the bed capacity requirement and to confirm whether the allocation of beds should be determined by the pathway. A comment was made that it was difficult to compare data pre and post centralisation. The Vascular Network Manager reported that the Registry data went from January to December and there had been issues with data input. The Chair highlighted the apparent discrepancy in figures from 2017 to 2020. The Executive Medical Director accepted this and agreed that the earlier figures were clearly incorrect. A member highlighted that anyone reading the report would accept the raw figures for amputations and would assume there had been a large increase since centralisation which was not the case. The Executive Medical Director accepted this and confirmed there was an ongoing proactive process to disseminate the correct data.

*[Louise Brereton rejoined the meeting]*

**QS21/47.3** A discussion took place around the delay with agreeing the diabetic pathway and the Chair referred to an earlier associated conversation as part of the corporate risk register. She also recalled that there had been agreement at Board level some time ago that the diabetic pathway would be prioritised for review. The Executive Medical Director responded

that the desired pathway had been identified and now that the right clinicians had been brought together he was hopeful that more progress could be made. The pandemic and changes in leadership had also contributed to challenges in making progress. The Executive Director of Primary and Community Services advised that for various reasons, the decision had been made to de-prioritise the review of the diabetic pathway. He added that it was crucial to get social and primary care aspects of this pathway right. The Executive Director of Therapies and Health Sciences highlighted the work ongoing within the podiatry service, and the care closer to home principles which were also relevant to this pathway.

**QS21/47.4 It was resolved that** the Committee note the progress made by the Vascular Task and Finish Group

**QS21/48 Sub Group Chairs' Triple A Reports**

**QS21/48.1 Strategic Occupational Health and Safety Group**

**QS21/48.1.1** This consent item was noted

**QS21/48.2 Patient Safety Quality Group**

**QS21/48.2.1** This consent item was noted

**QS21/48.3 Clinical Effectiveness Group**

**QS21/48.3.1** This consent item was noted

**QS21/49 Quality Improvement Strategy and Patient Safety & Experience Strategy**

**QS21/49.1** The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience gave a short verbal position statement, highlighting that whilst operational pressures had caused the engagement workshops planned for January to be suspended, the drafting of the Strategy continued.

**QS21/50 Issues Discussed in Previous Private Session**

**QS21/50.1** It was resolved that the Committee note the report

**QS21/51 Documents Circulated to Members**

**QS21/51.1** It was noted that the following had been circulated:

14.1.21 Q3 and Q4 Operational Plan Monitoring Report as at November 2020

15.1.21 Quality and Performance Report as at November 2020

27.1.21 Limited assurance reports from Audit Wales on 1) Quality Impact Assessment and 2) Continuing Health Care

22.2.21 Dental briefing note

**QS21/52 Issues of Significance to inform the Chair's Assurance Report**

To be agreed with Chair

**QS21/53 Date of Next Meeting**

4th May 2021

**QS21/54 Exclusion of Press and Public**

**QS21/54.1 It was resolved that** members of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.

BCUHB QUALITY, SAFETY& EXPERIENCE COMMITTEE - Summary Action Log Public Version				
Officer/s	Minute Reference and summary of action agreed	Original Timescale	Latest Update Position	Revised Timescale
<b>3<sup>rd</sup> November 2020</b>				
M Smith  T Owen	<b>QS20/203.1</b> Establish timeframe for reviewing pathway of admission to medical wards with the MHLDS Medical Director and feed back outside of the meeting.	30.11.20	15.1.21 M Smith confirmed this had been resolved. 2.3.21 L Reid asked that this action be re-opened and members be informed of the outcome. 16.3.21 T Owen confirmed that the CAG endorsed the MHLDS clinical winter plan on the 6.11.20 and Exec Team approved on the 19.11.20.	Closed  23.3.21
<b>15<sup>th</sup> January 2021</b>				
G Harris	<b>QS21/9.3</b> Follow up the matter of a communications plan for the Holden report recommendations, involving the CHC	31.1.21	19.1.21 Meeting arranged between CHC and M Joyes on 25/01/2021. 2.3.21 A member enquired whether a communications plan was now available. G Harris confirmed that different options were being explored and she would ensure an update be provided in due course. 27.4.21 The Health Board is continuing discussions with the ICO and will update the Committee fully once these are concluded.	Closed  May  July
M Smith	<b>QS21/10.2</b> Ensure that next routine report from the MHLDS division provided a higher focus on engagement with stakeholders and partners	21.4.21 (deadline for May papers)	M Smith confirmed in hand for May meeting.	closed
L Brereton	<b>QS21/20.1</b> Pickup concerns around reporting lines for safeguarding matters as part of a wider review of CoBs	2.3.21	17.2.21 L Brereton confirmed matter will be addressed through the ongoing review of the Board and Committee business cycles linked into the governance review work. 2.3.21 L Brereton confirmed that mapping of cycles of businesses was being progressed alongside the	Update to be provided in May

			governance review, and assured the Committee that safeguarding reporting would be picked up but the timescale for completion of this action would need extending. L Reid agreed to this extension. She also reported she was meeting with M Denwood regarding reporting to the MHAC. 26.4.21 Safeguarding item was deferred, with Chair's agreement, to the July Committee	July
<b>2<sup>nd</sup> March 2021</b>				
S Evans-Evans L Brereton	<b>QS21/39.2</b> Take on board comments regarding grammar and terminology, and a suggestion that the BAF and CRR might be clearer submitted as two separate agenda items.	21.4.21 (deadline for May papers)	26.4.21 Quality Assurance process for reports has been reviewed. BAF/CRR reports will be separated for all committee reporting from next committee cycle.	Closed
T Owen L Brereton	<b>QS21/39.3</b> Review controls in BAF20-08 and make learning aspect more visible	23.3.21	26.4.21 Controls have been reviewed as part of BAF risk review process. Learning as a control requires further reflection within the BAF risk.	
G Harris L Brereton	<b>QS21/39.3</b> Review controls in BAF20-11 and make learning aspect more visible	23.3.21	26.4.21 Risk reviewed with Risk lead. Further controls to be explored as part of next risk review.	
G Harris	<b>QS21/39.4</b> Determine with team their ambition for demonstrating improvement against CRR20-08 (clinical capacity re vision loss)	23.3.21		
<del>L Brereton</del> Simon Evans-Evans	<b>QS21/39.4</b> Arrange meeting with G Harris, L Reid, M Wilkinson and S Hill to work through cross-over issues on CRR20-08 (clinical capacity re vision loss)	23.3.21	26.4.21 Meeting being convened	
J Whitehead S Evans-Evans	<b>QS21/39.5</b> Arrange for further review of scoring of proposed new risk CRR20-09 (diabetes)	23.3.21	26.4.21 This risk has been removed from the register during the review process	Closed
S Evans-Evans	<b>QS21/39.5</b> Follow up with L Reid point of consistency in terms of escalating new risks	23.3.21	26.4.21 Completed	Closed

S Green	<b>QS21/41.2</b> Include demographic breakdown including socio-economic and ethnicity factors into next H&S report, together with themes from the Make it Safe reviews.	21.4.21 (deadline for May papers)	26.4.21 Following agenda setting meeting, Chair had indicated she did not require stand-alone H&S report to May meeting.	July
A Gralton	<b>QS21/42.2</b> Provide information outside of the meeting on face to face and remote consultation figures for neurodevelopment assessments of children and young people	23.3.21	26.4.21 IMs have not received this information. A Gralton has been asked to expedite on his return from leave.	
M Maxwell	<b>QS21/44.2</b> Follow up with L Reid the comments around content and presentation and ensuring actions addressed findings in mortality reports.	23.3.21	26.4.21 M Maxwell updated – meeting held with Committee Chair around Covid HCAI mortality work as part of a larger piece of work on learning lessons from Covid HCAs more generally. At the time of the meeting the definitive review list for deaths had been made available to sites and it was clear that the backlog of stage 2 reviews will take time to complete. A further action was taken away for M Maxwell to consider guidance and emergent information timelines could be superimposed on the learning. CEG will consider the timeline for stage 2 reviews.	
A Kent	<b>QS21/46.3</b> Reflect on comments and expectations around ensuring a richer narrative for future planned care papers.	21.4.21 (deadline for May papers)	26.4.21 Planned Care item was deferred, with Chair's agreement, to the July Committee	July
M Joyes	<b>QS21/45.3</b> Clarify figures for inquest information contained within the patient safety report.	23.3.21	4.3.21 Clarification sent to relevant IM and Chair	Closed

27.4.21



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<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	Quality, Safety and Experience Committee 4 <sup>th</sup> May 2021					
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public					
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	Patient Story					
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Gill Harris, Executive Director of Nursing and Midwifery/Deputy Chief Executive					
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Matthew Joyes, Acting Associate Director of Quality Assurance Carolyn Owen, Head of Patient and Carer Experience					
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	Review by: - Gill Harris, Executive Director of Nursing & Midwifery/Deputy CEO - Matthew Joyes, Acting Associate Director of Quality Assurance - Presentation at the Secondary Care Patient Safety and Quality Group, Corporate Patient Safety and Quality Group and Corporate Patient and Carer Experience Group					
<b>Atodiadau</b> <b>Appendices:</b>	Patient Story					
<b>Argymhelliad / Recommendation:</b>						
The Quality, Safety and Experience Committee is asked to receive and reflect upon the patient story.						
<b>Ar gyfer penderfyniad /cymeradwyaeth</b> <b>For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth</b> <b>For Discussion</b>		<b>Ar gyfer sicrwydd</b> <b>For Assurance</b>		<b>Er gwybodaeth</b> <b>For Information</b> ✓
<b>Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol</b> <b>Y/N to indicate whether the Equality/SED duty is applicable</b>						N

## Introduction

This story is a wife's recollections of her husband's illness from diagnosis, through to his eventual death. Ceri has been able to, with reflection; highlight both positive and negative aspects of her husband's, and indeed her own care and treatment pathway. This balanced view enables clear areas of both excellent practice, and those areas in need of service development to be identified.

## The Story

This patient story was the first recorded by audio as part of the Digital Patient Story Project. The audio file can be accessed by members here:

[https://nhs.uk/medias/365/sharepoint.com/sites/BCU\\_PSE/Shared Documents/Forms/AllItems.aspx?id=/sites/BCU\\_PSE/Shared Documents/Pt Stories - PJM/Ceri v4.wav&parent=/sites/BCU\\_PSE/Shared Documents/Pt Stories - PJM](https://nhs.uk/medias/365/sharepoint.com/sites/BCU_PSE/Shared Documents/Forms/AllItems.aspx?id=/sites/BCU_PSE/Shared Documents/Pt Stories - PJM/Ceri v4.wav&parent=/sites/BCU_PSE/Shared Documents/Pt Stories - PJM)

## Key Themes

- The patient became 'invisible' as he was so quiet, "the perfect patient". When his wife tried to 'speak for him', this was at times seen as interfering
- The channels of communication were not always open, when receiving treatment from other centres of care, in this case Liverpool. The passport helped.
- The lack of knowledge by non-BCUHB when treating complex cancer cases. "The use of bank staff was not received very well"
- Patient passports for those with chronic conditions, not only enables time sensitive, individualised treatment. This also made Ceri feel that she was "part of a team when it came to her husband's care", and her desire to be involved. Ceri also felt strongly that it saved his life on a number of occasions.
- The North Wales Cancer Treatment Centre (NWCT) was fantastic, with both the nursing and clinical staff respecting the patient as a person which was so important"
- Information was not always forthcoming on her husband's condition.

## Learning/Actions

- Patient Experience training has been rolled out with a strong focus on communication being a central tenet to the experience of those receiving care, in any care setting.
- *"Keep doing what you are doing at the NWCTC, it is a superb facility."* The story has been shared at the Secondary Care Patient Safety and Quality Group, Corporate Patient Safety and Quality Group and Corporate Patient and Carer Experience Group to share learning across the organisation. The Patient and Carer Experience Team will also support the centre to produce a case study on their positive work.
- Further training and information for external agencies in relation to complex cancer patients. This has been relayed back to service leads.
- The use of a patient passport and its benefits was a standout comment in relation to the patient's time with us. Whilst some departments, such as cancer services use these, it is a recommendation that these be considered by a whole range of services.
- Initiatives are being trialled, such as digital portal, which will allow some patients, if opted in further access to hospital letters etc.



# QSE Committee Meeting 4<sup>th</sup> May 2021

(Data up to and including that reported 19/4/2021)

## Ysbyty Gwynedd Covid 19 Outbreak Presentation

# *Outbreak of COVID -19*

- 1<sup>st</sup> ward declared in Ysbyty Gwynedd on the 1st February 2021.
- Level 3 outbreak on the 22<sup>nd</sup> February 2021 declared in line with BCHUB policy (IPC05) Outbreak reporting and control procedure.
- Ongoing independent review looking at the escalation, preparedness of the site and implementation of learning from other sites pre outbreak which is due at the end of April.

# *What may have been the contributing factors?*

- **Complacency**
  - We managed it before, did we think we that wouldn't work this time?
  - Did we 'protect staff groups' outside of red areas: some staff said 'what outbreak'
  - Daily communications and assumed messages received, but on testing, messages weren't clear / received
- **Understanding of changes between 1<sup>st</sup> wave to 2<sup>nd</sup> wave**
  - Pressures from different clinical pathways
  - Guidance changed as understanding about the virus improved
  - Vaccinations introduced with pressures on staff for provision and perception of risk
  - Even 12m on with tired staff there is a need to continue to embed practice to prevent spread
  - In 1<sup>st</sup> surge everything stopped and there was lost of capacity (3.6m spacing would have been easily achievable), in the second surge at L3 majority of HB functions gone back to BAU

# *What may have been the contributing factors?*

- Human desire for interaction / guidance / support is the norm?
  - Social interaction
  - Visitor Policy challenges
  - Communication
  - Command and Control in the 1<sup>st</sup> wave had implications for preparedness going into the 2<sup>nd</sup> wave in hindsight
  - Escalation and communication

# *What may have been the contributing factors?*

- Ability to move from insights to intervention, share the learning and embed the actions?
  - Focused inward
  - Seeking permission
  - Confidence to challenge
  - Lack of evidence / facts
- Historical 'issues'?
  - Old infrastructure gives old ventilation
  - No HPV cleaning programme at YG due to decant facilities and insufficient domestics capacity (volunteers supported in 1<sup>st</sup> wave)
  - Lack of changing facilities
  - Little segregation
  - Minimal door closure mechanisms – work progressing

# *Control Measures, Initial Learning and 4 Key Themes*

- Leadership and Behavioural
- Operational/Practice
- Technical
- Infrastructure

# *IPC measures pre and during outbreak*

- Education and training
- COVID monitoring
- CAG approved clinical pathways and local SOPS
- Red / green workforce rotas
- Estates measures
- Escalation plans Staff and Non Clinical Patient Movement
- Fit testing programme
- Vaccination program – flu and COVID
- Senior scrutiny of visiting
- Resource allocation to support IPT

# *Lessons Learned*

- Control measures not implemented consistently
- PPE training and instruction (some staff groups not trained and gap in refresher training for many)
- Risk of wandering patient
- Social distancing / behaviours particularly in staff welfare areas and kitchens.
- Changing facilities not optimised nor adequate
- False assurance from LFD, vaccination, negative swab results
- Lack of breadth and depth of H&S knowledge
- Importance of visible leadership



## *Lessons Learned (2)*

- Lack of networking
- Risk of stepping down governance process
- IP everybody's business - held primarily by nursing/ IPT
- Sustainability of red / green rotas across most professional groups
- Underestimating the challenge of behaviour change

# *Share learning across the organisation*

- More outward facing
- Communications – ‘Clear is Kind’
  - Formal and informal fora

## *Embed and sustain lessons*

- Engage in Safe, Clean, Care, Harm Free program.
- Plan on page
- Data driven and monitoring
- Make it easier for people to do the right thing
- Continuous learning
- Engage in Stronger Together



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<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	Quality Safety and Experience Committee 4 <sup>th</sup> May 2021					
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public					
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	Covid-19 update					
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Gill Harris, Executive Director of Nursing & Midwifery Chris Stockport, Executive Director of Primary & Community Care					
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Co-ordinated - Sally Baxter, Associate Director – Coronavirus Co-ordination Unit Programme reports produced by senior strategic leads					
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	Executive Director of Nursing & Midwifery Chief Executive					
<b>Atodiadau</b> <b>Appendices:</b>	Appendix 1: vaccination data Appendix 2: staff vaccination tables Appendix 3: Testing strategy summary Appendix 4: Nosocomial Action Plan					
<b>Argymhelliad / Recommendation:</b>						
The Committee is requested to note the position outlined in this report and provide comments on progress of the programmes.						
Please tick as appropriate						
<b>Ar gyfer penderfyniad /cymeradwyaeth</b> <b>For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>	<b>x</b>	<b>Er gwybodaeth For Information</b>
<b>Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol</b> <b>Y/N to indicate whether the Equality/SED duty is applicable</b>						<b>N</b> The report is brought for assurance. As the next stages of plans are developed – e.g. for the vaccination programme – the SED will be considered and future plans will take the duty into account.
<b>Sefyllfa / Situation:</b>						
The Health Board has now been dealing with the impact of the Coronavirus pandemic for just over a year. During that time there have been separate waves of increased Coronavirus levels within our communities with corresponding impact on our population, patients, staff and services. However, in the last month or so, levels of community transmission have been reducing across North Wales. This report provides an update on key programme areas of the Covid-19 response during the recent months and issues of significance.						
<b>Cefndir / Background:</b>						

The programmes established to respond to the pandemic have been working to address the immediate impact and also to ensure readiness to respond to incidents, outbreaks and future trends. In each area there have been changes as lessons are learned and the response amended. This report summarises some of the more significant issues in respect of:

- Vaccination
- Test, Trace and Protect
- Health and Safety
- Infection Prevention and Control

It should be noted that there are mandated (and in respect of certain areas, statutory) reporting requirements in respect of all programmes.

## **Asesiad / Assessment & Analysis**

### **Strategy Implications**

The programmes work within and respond to national and BCUHB strategy in respect of the pandemic including the Welsh Government (WG) Coronavirus Control Plan (revised March 2021.) Associated with this is the range of more specific strategies including, for example, the Testing Strategy, and the national Vaccination Strategy. In respect of Health and Safety, the Health Board is in the process of implementing the Occupational Health & Safety (OHS) 3-year Strategy.

### **Options considered**

Each of the programmes has considered options in respect of the model of operation as appropriate (such as vaccination delivery models.) As each programme is now well established, the consideration of options is relevant to ensure ongoing response to revised national strategy and local circumstance. There are limited alternative options other than compliance with legislation and guidance. Furthermore, failure to implement recommendations in respect of Health and Safety may result in criminal proceeding against the body corporate or individuals.

### **Financial implications**

There are significant budgetary implications arising from the pandemic response which are recorded and reported against Covid budgets. In respect of Health and Safety, a business case is being further developed and will be shared with the relevant Executive Directors. All programmes are incurring costs against Covid funding. Ongoing funding for Test, Trace & Protect (TTP) and vaccination programmes remains to be confirmed.

### **Risk analysis**

The significant risks have been escalated to the Board Assurance Framework (BAF) and were previously agreed by the Quality, Safety & Experience (QSE) Committee. A separate report on the BAF is on the agenda for the meeting. These include Infection Prevention Control (IPC), Health and Safety (H&S) and overall Covid programme risks.

### **Legal and compliance**

Failure to comply with Health and Safety legislation can lead to the increased risk of accidents and incidents occurring and the risk of enforcement action, prosecution, fines and compensation claims.

Failure to comply with Covid related regulations might also lead to fines and potential future compensation claims.

## **Impact Assessment**

The newly established and defined programmes, including Vaccination and TTP, have undertaken Equality Impact Assessment and are continuing to review the action plans and mitigations on an ongoing basis. The Equality Stakeholder Reference Group has been approached for contribution to the ongoing development of vaccine equity plans, and there has been broader engagement with specific groups on Covid-related matters, led by the Engagement Team.

### **- VACCINATION PROGRAMME**

#### **1.1 Overview**

The Vaccination Programme is now well-established and progressing through delivery of first and second doses for all priority groups. At the time of writing, the programme has delivered 527,292 doses since it started in December 2020. That means we have averaged 4,400 vaccines a day, averaging 367 man hours a day every day of vaccinators since the start of the programme, at 5 minutes per vaccine. On our busiest days we can see over 9,000 citizens. Our busiest weeks see us vaccinate over 50,000 citizens. Progress against the milestones is as set out below:

- Phase 1 target date 14<sup>th</sup> February 2021 MET
- Phase 2 target date 18<sup>th</sup> April 2021 MET
- 91% cohorts 1-9 have been vaccinated 1<sup>st</sup> dose
- 96% of Phase 1 (Cohorts 1-4) 176,872
- 85% of Phase 2 (Cohorts 5-9) 171,595
- Phase 3 target date 31<sup>st</sup> July 1<sup>st</sup> dose ON TARGET
- 12% of Phase 3 (Cohort 10) 24,597
- 1<sup>st</sup> Dose vaccination rate to date across all cohorts 64% 373,015k
- We have circa 169k citizens remaining to book for a 1<sup>st</sup> dose
- 26% of citizens have had both doses

We believe we have contacted all citizens in cohorts 1-9; however, we recognise that the contact information we have may not be correct for a small minority of citizens. We have therefore developed a form for eligible citizens in cohorts 1-9 only that have not yet been contacted to complete on the BCUHB website to update their contact details to enable an appointment to be booked.

#### **○ Cohort 10**

Bookings are being sent out for Cohort 10 over the coming weeks to ensure that the target of 31<sup>st</sup> July for all to have received an offer of 1<sup>st</sup> dose appointments. All citizens will be offered a clinically appropriate vaccine in line with Joint Committee on Vaccination and Immunisation guidelines. Health Boards are working closely with Public Health Wales (PHW) to ensure that vaccine supply is in line with local demographic requirements. We are also working closely with the Welsh Government and the Just in Time distribution of vaccine to BCUHB and the subsequent booking of citizens.

#### **○ Unpaid carers**

We have been successful in identifying unpaid carers and have so far had 4,962 returns that we are booking in for their 1<sup>st</sup> dose vaccine.

## **1.4 18 – 29 year olds**

We are working closely with Pharmacy and the Welsh Government in relation to recent announcements regarding Astra Zeneca and the Joint Committee on Vaccination and Immunisation (JCVI) and MHRA guidance that the 18-29 age range should be offered an alternative for 1<sup>st</sup> dose. For people aged 18 -29 years without a health condition that puts them at greater risk from COVID-19, the JCVI currently advise that it's preferable to have a different COVID-19 vaccine instead of the AstraZeneca vaccine if they have not yet been vaccinated. If you are aged 18 to 29 years and have already had your first dose of the AstraZeneca vaccine it is recommended that you have the AstraZeneca vaccine for your second dose. The MHRA confirmed on 7 April that the 79 cases, after more than 20 million doses of AstraZeneca vaccine had been given in the UK, were reported after first doses and there had been no confirmed cases of extremely rare blood clots after the second dose of the AstraZeneca vaccine.

### **○ Programme issues and risks**

- Impact of change in use of Astra Zeneca to under 30's
- Unstable vaccination supply of Astra Zeneca
- Limitations of storage and transportation for Pfizer vaccine risks programme delivery to rural disadvantaged population of under 30's
- Unreliable address and telephone contact details in Welsh Informatics Services (WIS)
- Planning on decommissioning and commissioning of new sites under way
- Long term planning of booster programme reliant on development of options by Welsh Government
- Timings of public communications from PHW continue to create local challenges due to timings of release
- Reliance on WIS and lack online patient portal for bookings and rebookings has led to the need to create resource intensive manual solutions to manage process.
- Programme is currently 64% through phase one of the vaccination programme ensuring that citizens of North Wales are offered and able to receive the vaccine. However, it is now entering phase two, decommissioning and planning for phase 3 the ongoing booster programme. There is a risk that as BCUHB brings services back to business as usual (BAU) the focus will be lost on the vaccine programme as 'staff, stakeholders and the public' believe it to be in a BAU state.

## **1.6 Staff Vaccination Programme**

### **1.6.1 Background**

The staff vaccination programme for staff in JCVI group 2 commenced on 8 December 2020 in Hospital Vaccination Centres (HVCs) at Wrexham, Glan Clwyd and Bangor. Small numbers in high risk areas were vaccinated to the end of December, then HVCs operated at capacity throughout January 2021. HVCs closed for 1<sup>st</sup> doses by 29<sup>th</sup> January 2021.

As well as BCU staff, students on clinical courses, and staff working in BCUHB but employed by other organisations were included in the programme. This includes junior doctors in training, Public

Health Wales, Microbiology and security staff. Staff received an invite to book an appointment via text message and their NHS Wales email account (using information held on the Electronic Staff Record - ESR).

It was originally set out that all BCU staff would be vaccinated in HVCs, with all other priority groups in the population directed to the Mass Vaccination Centres (MVCs). However, significant numbers of staff were invited to MVCs to ensure no wastage, particularly in the early weeks of the vaccination programme as systems were put in place. This resulted in staff in priority groups 3-4 also receiving invites to HVCs in the latter weeks of the programme, as well as external bodies in group 1-4 such as funeral directors. A staff vaccination queries email address was opened in early January 2021, and staff were invited to contact the team with queries including not being invited, and eligibility in group 2. Management of the emails was undertaken by members of the Human Resources team, who combined this activity with their 'day jobs'.

HVCs reopened for 2<sup>nd</sup> doses on 16 February 2021 and closed week commencing 15<sup>th</sup> March 2021. For the 2<sup>nd</sup> dose, staff received a text message and letter with an appointment time. Staff were mainly directed to the location for their 1<sup>st</sup> dose, but there were a number of issues whereby staff were invited to a different location, which resulted in a significant number of queries. The numbers directed to a different centre were too great to correct, so remained unless requested by staff. Staff who received their 1<sup>st</sup> vaccine at an MVC received an invite to the same location for their 2<sup>nd</sup> dose. A very large number of staff also requested appointment time changes, which were dealt with by the team. The staff queries in box dealt with over 13,500 emails in an 11 week period. A number of notifications were issued to staff over the weeks from January to March, requesting that they contact the team by email if not invited for 1<sup>st</sup> / 2<sup>nd</sup> dose.

### 1.6.2 Demographics

Table 1 (See Appendix 2 for tables) indicates the numbers and percentage vaccinated with at least 1 dose for priority groups 1 – 4. This includes bank staff and staff working, but not employed in the organisation – a total of 17,777 staff have been vaccinated with an uptake of 84.6%. A number of staff were unable to have their 1<sup>st</sup> jab within this time period and have been invited to MVCs (approx. 800) – so this number will increase over the coming weeks. This is significantly higher than uptake for the very successful flu vaccination programme in winter 2020.

Table 2 - excludes bank staff and indicated the numbers and percentage vaccinated with at least 1 dose for priority groups 1 – 4 by staff group and locality:

East 87.5%  
Centre 88.9%  
West 89%

Table 3 - demonstrates the numbers and percentages vaccinated by Division in priority groups 1 – 4.

Table 4 - provides a breakdown of all staff who have received 2 doses in the Health Board by Division.

Table 5 - provides a breakdown of black, Asian and minority ethnic groups.

Table 6 - provides a breakdown by pay bands, showing demographic of vaccines.

### 1.6.3 Ongoing vaccinations

All HVCs have now closed, and the residual vaccination activity required for staff falls into 3 categories

- Employees awaiting 1<sup>st</sup> / 2<sup>nd</sup> dose







- New employees in priority groups 1 – 4
- Employees who have not taken up offer of vaccination

### 1.6.4 Employees awaiting 1<sup>st</sup> / 2<sup>nd</sup> dose

All staff in priority groups 1 – 4 who had not received / had an appointment for 1<sup>st</sup> / 2<sup>nd</sup> dose were asked to email the staff Covid queries inbox by Thursday 18<sup>th</sup> March 2021. List were compiled and forwarded to the central vaccination team for invite to MVCs. After the HVCs closed, the vast majority of the queries into the [BCU.StaffCovidVaccinationQueries@wales.nhs.uk](mailto:BCU.StaffCovidVaccinationQueries@wales.nhs.uk) email address, was solely compiling lists for MVCs only and responding to queries requesting updates for an appointment for an MVC. Therefore all email traffic was diverted to [BCU.CovidStaffVaccinationBooking@wales.nhs.uk](mailto:BCU.CovidStaffVaccinationBooking@wales.nhs.uk) by close of play on 25th March 2021.

### 1.6.5 New employees in priority groups 1 – 4

The draft process is detailed below:

Covid Vaccination Pathway For Occupational Workers Who Have not had The Covid Jab to Date – Draft 19.03.2021				
BCU Staff & Bank Staff				Non BCU staff
Dose 1	Dose 2 Astra	Dose 2 Pfizer	Large intakes	All scenarios
<ul style="list-style-type: none"> <li>New starter not had vaccination previously</li> <li>Work in Health Board but not had to date               <ul style="list-style-type: none"> <li>DNA</li> <li>Previous decliner</li> <li>Had illness</li> <li>Previous contraindication</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>New starter and had 1st jab elsewhere</li> <li>Due dose 2 and out of schedule – recommence full course</li> </ul>	<ul style="list-style-type: none"> <li>New starter and had 1st jab elsewhere</li> </ul>	e.g. students(400 in September) Large recruitment drive of 100 plus	For all doses & scenarios
Assess whether had Jab and date of previous jab Offer vaccinations within scheduled time scale				
				
At Occupational Health & Wellbeing Site		Go MVC	Go MVC	Go MVC

#### ▪ Considerations

- Access to supplies of AstraZeneca (AZ) vaccine
- Occupational Health staff trained to operate the WIS system
- Occupational Health staff trained to support delivery of AZ vaccine
- Require a multiple of 10 people booked on each site at any one time to administer AZ vial
- Require vaccines with long expiry dates
- Standard Operating Procedure for delivery across the 3 regional sites
- Identified areas for observation post vaccination
- Pending details of numbers of new starters

### 1.6.7 Staff who have not taken up the offer of the vaccine

Lists of staff who did not take up the offer of the vaccine following their 1<sup>st</sup> dose invites to HVCs (around the end of January), were forwarded to managers to enable them to have conversations re the benefits of vaccination. This will inevitably result in additional staff requesting a jab, but these have to be forwarded to MVCs. An additional exercise will now be undertaken with managers, but it should be noted that this is likely to generate additional concerns who have still not been able to have the 1<sup>st</sup> jab.

## 1.7 Next steps

The vaccine programmes decommissioning cell is in place and estates along with Area representation are actively working through their plans to decommission the 'Nightingale' elements of the MVC's whilst ensuring that the vaccination programme can continue to function to meet local and national targets. This does require changes to the access ways for citizens and moves within the 3 MVCs that enables the decommissioning work to go on around the vaccine delivery. We are also seeking new locations to support the longer term model and sustainable delivery, but this is linked to the Booster Programme. The work on the Booster programme and long term plan has started, looking at the management requirements going forwards centrally and within each area. There are however significant unknowns that require direction from Central Government on the options of what the Booster programme will be, ranging from the vaccine to be used; the cohorts to be targeted; the time frame for delivery. It is anticipated that we will shortly receive an update that outlines 3 to 4 options which we will need to review and understand the implications and plan how we would implement each within BCUHB.

### - TEST, TRACE AND PROTECT

The TTP programme in North Wales went live on 01 June 2020. It is a multiagency activity with BCUHB as the lead agency driving the programme forward. The TTP Programme in North Wales is being managed on a regional footprint under the leadership of the Executive Director of Public Health. A multi-agency response comprising members of the Health Board, the BCU public health team and the six Local Authorities has been established to operationalise the response plan within the region.

Testing people to identify those who have Covid-19 is one part of our overall programme to control the spread of Covid-19. Tracing those people who have been in close contact with a person who has tested positive, and providing advice and guidance is critical to stopping the virus spreading through our communities.

The NHS Covid-19 app, alongside traditional contact tracing staff, is used to notify people if they come into contact with someone who later tests positive for coronavirus. It is important that there is a seamless link between testing and tracing.

- **Testing** people with coronavirus symptoms, asking them to isolate from wider family, friends and their community whilst waiting for a result. Testing has now been extended to incorporate testing asymptomatic individuals to identify those who are positive but do not show symptoms.
- **Tracing** people who have been in close contact with anyone who tests positive, requiring them to take precautions through self-isolation for 10 days.
- **Protecting** the vulnerable or those at risk from the virus, providing advice, guidance and support, particularly if they develop symptoms or have been identified as a contact through the contact tracing process.

Since the service was established there have continued to be significant developments in the TTP service for North Wales:

- A multi-agency response to Test, Trace and Protect has been developed through strong partnership working to respond to infections across North Wales, the largest region in Wales.
- New testing capabilities developed and rapidly responded to and testing capacity increased.
- A new digital system to support the tracing service and various system developments adopted to support the tracing of positive cases and their associated contacts.
- New Variants of Concern are monitored, identified and responded to rapidly to eliminate further transmission.
- Despite various lockdown and restriction measures, and Tier 4 arrangements, a significant surge of positive cases across the region in December 2020 through to February 2021.
- The population has been supported to isolate through an isolation payment grant and a network of voluntary services.
- The test and trace services have responded to a multitude of outbreaks and clusters across the region and within the Health Board, supporting Incident Management Teams (IMTs) to manage and resolve the immediate cluster.
- Welsh Government (WG) have issued a refreshed Testing Strategy, and several new requirements for tracing and protect are responded to rapidly.
- Recruitment remains a challenge for test and trace due to the temporary nature of the service.
- Modelling for the future is a challenge as the benefits of the vaccination are understood whilst there remains significant threat of new variants of concern.
- An audit report by the Wales Audit Office reported that the TTP service had had a positive impact on the response to Covid.

In summary, it has been reported that the impact of the TTP service reduced the R number by 0.35. Whilst the vaccination programme is a positive development in the response to reducing the impact of Covid-19, TTP will remain an important service alongside the vaccination programme for the foreseeable future, until the extent of the clinical effectiveness against transmission and new variants is understood and a greater proportion of the population is vaccinated.

## **2.1 Overview of Programme**

Testing in response to Covid 19 started in April 2020 in advance of the wider programme. On 4<sup>th</sup> May 2020, the Chief Medical Officer (CMO) announced the requirement to establish the Test, Trace, Protect programme and officially on 1<sup>st</sup> June 2020, the Test, Trace, Protect programme was launched in Wales. Since this time, the service has grown rapidly, often needing to respond to new developments and challenges at short notice.

The service had a challenging start managing a surge of cases in the first eight weeks of operations, far exceeding activity across the rest of Wales. There was a resurgence of activity in autumn as mobility increased and schools returned. Whilst the rest of Wales experienced extremely high volumes of virus transmission during this time, North Wales benefited from the two week firebreak at the end of October 2020. However, the period from early December 2020 to the end of January 2021 was the busiest period the TTP service has experienced since the start of the pandemic with the rate and volume of tests, positive cases and associated contacts far exceeding those experienced in the Spring of 2020.

TTP resources have been stretched, but remained resilient during this time, with a brief period (between 23 December to 2 January), when the tracing service was not able to cope with the volume of incoming positive cases, and prioritisation was enacted.

It should be noted that between 1<sup>st</sup> December and 31<sup>st</sup> January, in excess of **180,000** tests were undertaken in North Wales and just under **19,000** positive cases, with **30,000** associated contacts traced.

Since the peak in January, the demand for testing and the resulting positive cases has reduced dramatically. Whilst the vaccination programme has made positive progress, the TTP service continues to monitor activity, public behaviours and variants of interest/ concern closely to minimise the impact of the virus continuing to transmit and potentially leading to a third wave.

## 2.2 Testing

The testing capacity and capability has grown dramatically over the last 12 months. By December 2020, the region had capacity for 28,600 polymerase chain reaction (PCR) tests every week, delivered through a number of mediums to serve keyworkers and the public across the region. (Capacity increased to 32,000 slots per week by the end of January 2021.) The aim to limit travel to access a test to 30 minutes wherever possible. Test locations:

- Two regional testing sites; one in Llandudno, the other in Deeside
- Four local test sites; one each in Bangor, Rhyl, Connah's Quay and Wrexham
- Six mobile testing units moving across the region
- Four community testing units (CTUs); Alltwen, Bangor, Glan Clywd and Wrexham to support keyworkers and their households

In addition to this capacity, home test kits were available through the post.

The CTUs are resourced and run by the Health Board. The CTUs have flexed to provide additional capacity during periods of surge and when the alternative testing resource through Department of Health & Social Care capped capacity.

Antibody testing was undertaken for approximately three months – July to October 2020. The antibody programme was paused when positivity rates started to increase to enable all resources to focus on antigen testing to ensure the identification of positive cases was executed as quickly as possible. Antibody testing is currently under consideration by WG.

One in three positive cases demonstrate no symptoms at all. This is a major risk for the continued transmission of the virus. By December 2020, WG introduced an initiative to pilot lateral flow devices (LFDs); a test for asymptomatic people to proactively test and identify if they are Covid positive within 30 minutes. The aim is for this test to be conducted twice per week unless a participant has been confirmed as positive in the last 90 days. It supports people to identify if they are positive despite not showing symptoms and aims to protect the wider population.

Since the pilot in December, LFDs have been issued to >10,000 BCU staff (aim 17,000 by mid-May), care home staff, staff in education and social care staff. Effective 26 April, an LFD collect service is available for members of the community who are not already participating in a scheme and are not able to work from home. The LFD usage now exceeds PCR tests. However, the policy remains that a positive LFD requires a confirmatory PCR test and therefore the need for PCR capacity remains. In February 2021, WG launched a revised Testing strategy with five key approaches:

- Test to diagnose
2. Test to safeguard
3. Test to find

4. Test to maintain
5. Test to enable

Testing on its own does not remove or reduce the extent to which the virus is circulating in communities. Everyone, irrespective of whether they have had a test recently must maintain social distancing where possible, practise good hand hygiene and follow the guidelines on the wearing of face coverings in order to keep us all safe.

Testing can play a part in reducing the harms associated with Covid-19 and with the advancement of new testing technologies have demonstrated it is possible to test at far greater scale, frequency and speed than previously. Further detail on these five areas can be found in Appendix 3.

The rapid turnaround times (TATs) for tests is a key factor in the effectiveness of the TTP service. There were two periods when TATs were challenged; late August and September and early January. At these times, WG worked with UK Government to resolve the issues and the PHW laboratories absorbed as many tests as possible. Due to the emergence of variants of concern, all swabs are currently diverted to south Wales to enable genomic sequencing to be undertaken in the identification of variants. The added courier time for swabs has been monitored and this has not adversely affected TATs to date.

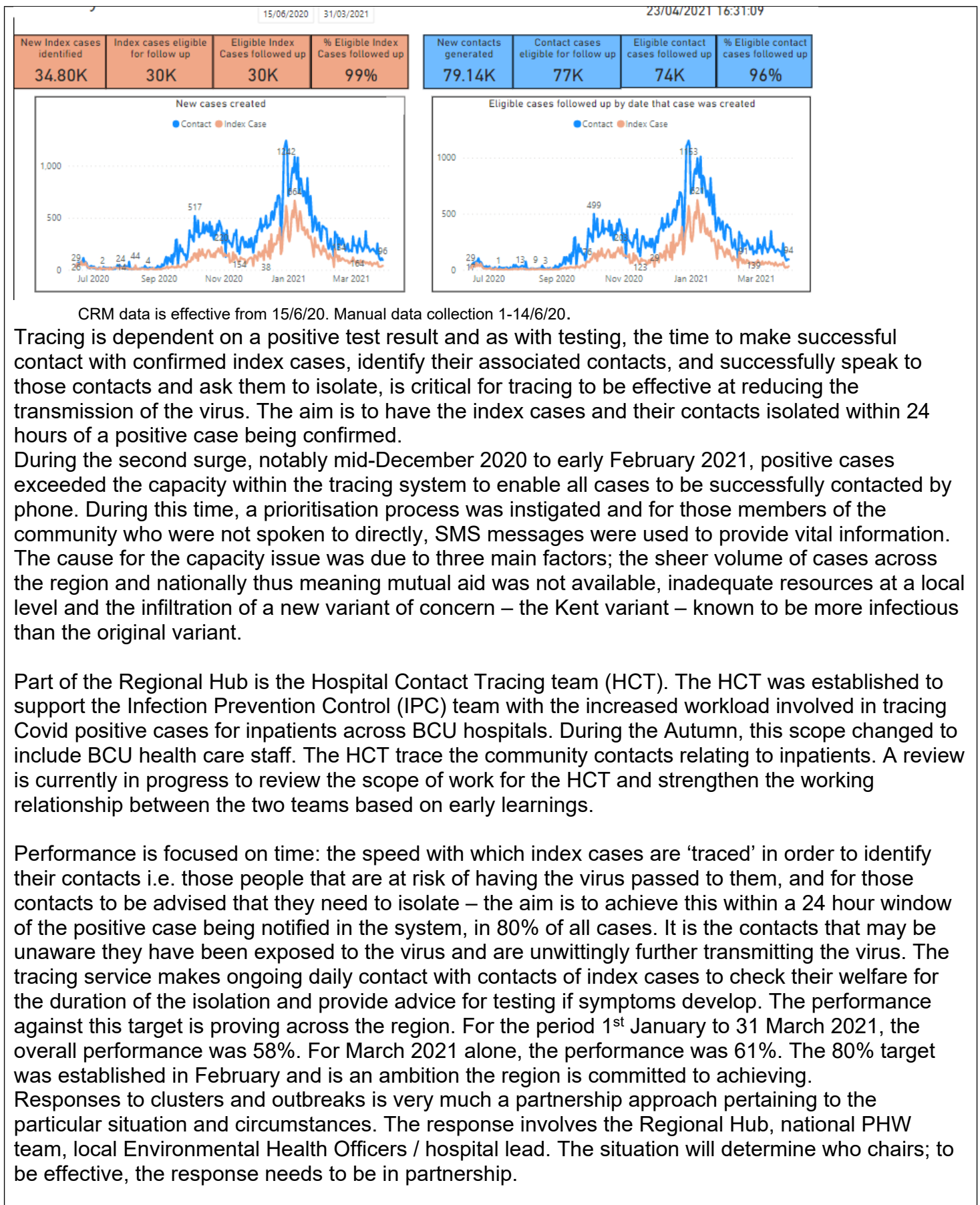
Responding to clusters, outbreaks and issues: The BCU testing team provides flexibility and agility when there is a need for a rapid response. Responding to whole home testing, outbreaks within the BCU hospitals, a ferry in Holyhead port, returning travellers from Red countries, travellers with suspected variants of concern. The response has coordinated by the BCU testing team, and in most cases provided through the CTUs, typically at short notice.

Testing will continue to play an important role alongside the vaccine in supporting us to save lives and livelihoods during 2021 and the longer term.

## 2.3 Tracing

The Tracing service is provided through a partnership response; the local tier responds to local positive cases, contacts, clusters, outbreaks and is managed by the six local authorities. The regional hub (tier) is run by the Health Board and manages more complex cases escalated from the local teams, clusters and outbreaks, and supports the development of policy and procedure. Whilst there is a partnership approach and shared responsibility, the Health Board is accountable for delivery of tracing in North Wales.

Since the service started on 1<sup>st</sup> June 2020, more than 35,000 positive cases have been reported and in excess of 79,000 contacts identified across North Wales.



As with testing, new developments for the tracing service are constantly being explored to identify cases and potential cases as early as possible in order to eliminate further onward transmission. Backward contact tracing (tracing backwards for up to 14 days compared to 2 days previously), opening telephone lines to take calls directly from the public and supporting the use of the NHS APP are all new expectations of the service.

Returning travellers present a significant risk in relation to introducing new variants of concern. Even with international travel restricted, there are circa 400 international travellers isolating in North Wales at any time. A significant amount of the work relating to returning travellers is now managed centrally by a national team. However, if international travel restrictions are lifted in the near future, it is anticipated that the volume of work may return to regions.

In the first instance, the tracing service is a response to a positive case. However, the effective tracing, identification and subsequent isolation of a contact reduces transmission of the virus and protects the population, resources within the NHS and the economy.

## **2.4 Protect**

Members of the community are asked to isolate due to a positive test, as a contact of a positive case or as part of shielding, the Protect work across the region seeks to provide support. The role of the Health Board is one of co-ordination and facilitation across the many organisations and services involved across the six Local Authorities, voluntary and Third Sector.

A recent development in progress, is a broader protect offer where several services are offered in one place to support communities and small businesses i.e. lateral flow test kits, food banks, Citizen's Advice Bureau. Supporting communities and small business to isolate or return to work whilst keeping them safe with local testing available.

## **- HEALTH AND SAFETY UPDATE INCLUDING RIDDOR REPORTING**

### **3.1 Corporate Health and Safety Team Site Visits**

With the onset of the Coronavirus (COVID-19) pandemic in March 2020 and the subsequent government advice to 'stay at home' on the 23rd of March 2020, the Corporate H&S reviews were placed on hold. With changes in restrictions of movement since this date the H&S team primarily focused on supporting the Hospital Management Teams and department managers with site visits to support with the 'social distancing and staying safe' program and later with undertaking risk assessments for staff returning from shielding. In Q4 a further 127 social distancing and staying safe visits were undertaken bringing the total for the 2020/21 year to 431. The Key Performance Indicator implemented in January 2021 is for one of the team to attend within 2 weeks of the request being made. All visits in Q4 were within this timescale.

The team also reintroduced on a small scale the formal Corporate Health and Safety reviews in Q3 as part of the BCUHB auditing process. In Q4 48 H&S reviews were undertaken giving an overall total of 85 Corporate Health and Safety reviews undertaken in 2020/21.

### **3.2 Corporate Health and Safety Team COVID-19 specific guidance**

Along with the site social distancing visits, the team have provided guidance documents since the beginning of the pandemic for all staff with advice on staying safe and keeping well. To date there have been 20 short guidance documents produced which have been regularly updated in line with Welsh Government guidance changes. These guidance documents included advice for staff working from home and particularly the use of laptops, mobile phones and tablets and guidance for additional controls for staff at increased health risk from COVID-19 as examples. The guidance documents are stored on the Corporate H&S team webpage and are linked into the team's Frequently Asked Questions (FAQs) document. This document was first produced on the 27<sup>th</sup> of March 2020 and to date there have been a total of 14 versions updated onto the webpage.

### 3.3 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

#### 3.3.1 Q4 RIDDOR incidents reported to the Health and Safety Executive

In Q4 the following RIDDORs have been reported:

Area	COVID-19 RIDDORs	Non-COVID-19 RIDDORs	Total Q4	Comparison total Q4 2019
East	40	7	47	3
Central	18	4	22	11
West	56	5	61	9
Total	114	16	130	23

#### 3.3.2 2020/21 RIDDOR incidents reported to the Health and Safety Executive (HSE)

For 2020/21 there have been 820 reports made to the HSE under RIDDOR, compared to the same period in 2019-2020, when 105 reports were made to the HSE. The significant increase is predominantly due to the numbers reported as Occupational Diseases following the requirement to report a person at work who has been diagnosed as having COVID-19 attributed to an occupational exposure to coronavirus. When comparing the non-COVID-19 related incidents reported under RIDDOR against the 2019-2020 figures, there has been a decrease of 30, with only 75 reports being made during this period. This is discussed in more detail further on in this paper.

Annual RIDDOR information from April 1<sup>st</sup> 2020 to March 31<sup>st</sup> 2021 compared with 2019/20

Report breakdown	2020/21 Total	2019/20 Total
COVID-19 related	745	0
Staff Injuries	57	88
Patient Injuries	18	17
	820	105

#### 3.3.3 COVID-19 Staff Cases reported to the Health and Safety Executive

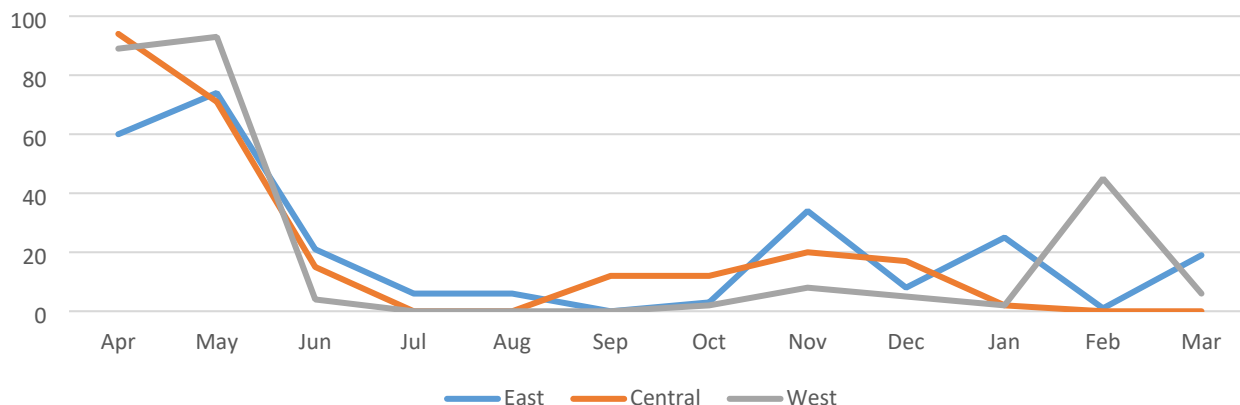
In the period 1<sup>st</sup> April 2020 to 31<sup>st</sup> March 2021, there have been 732 COVID-19 staff diagnosis reported as occupational diseases to the HSE under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

These break down into 86 identified COVID-19 staff clusters:

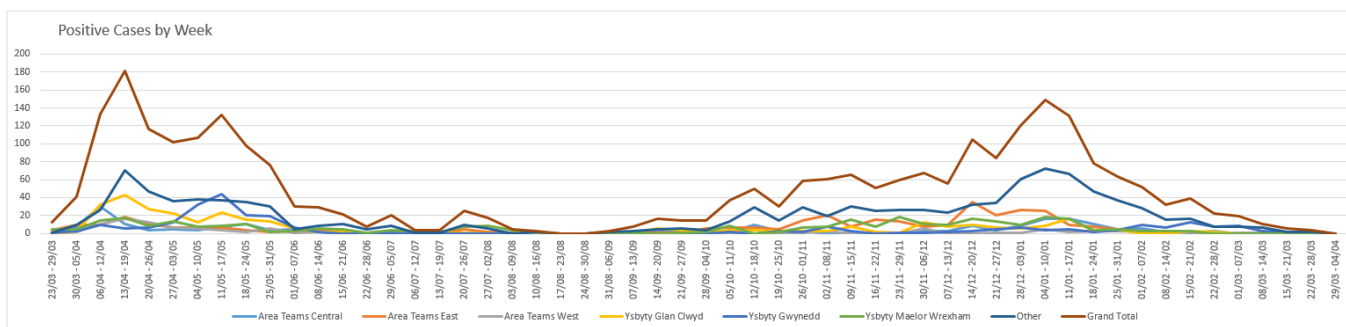
- 32 in East involving 235 staff
- 31 in Central involving 243 staff and
- 23 in West involving 254 staff.



**Annual Breakdown of COVID-19 staff cases reported under RIDDOR per month from April 1st 2020 - March 31st 2021**



The total number of positive cases by week has been provided by the Workforce Information teams below:



The Corporate Health and Safety Team supported the three area COVID-19 Outbreak Incident Management Teams (2 in East and 1 in Central). In July 2020, the team implemented a 72-hour review form to enable managers to collate the information required in a more structured way for reporting under RIDDOR to reduce the number being reported outside of the statutory timescale. The Corporate H&S team check all of the 72-hour reviews attached to Datix records to determine if the incident is reportable as an occupational disease.

In conjunction with the 72-hour reviews, the joint 'Make It Safe' (MIS) investigations that are held in conjunction with Clinical Services, IPC, PHW and H&S on all related COVID-19 outbreak clusters have identified a number of potential transmission sources.

These include:

- Potential breaches of Personal Protective Equipment (PPE) when providing hands on care, which includes caring for challenging patients
- Donning and doffing of PPE that is not of an appropriate standard
- Shortages of PPE in work areas
- Cramped staff rest/welfare areas making social distancing difficult
- Inadequate ventilation and air movement in work environments
- An absence of adequate changing facilities for staff

- Non-adherence to social distancing or the mandatory wearing of face coverings by both staff and patients
- Non-compliance with the Welsh Government recommendations regarding bed spacing
- Ineffective/insufficient cleaning regimes for high touch surfaces and equipment
- Inadequate COVID-19 Workplace or Workforce risk assessments for night and roaming staff
- Lack of supervisory visits and audits of PPE and social distancing compliance during all shifts

For these clusters, remedial action has been recommended and implemented to prevent reoccurrence. It is also now a mandatory requirement to have a COVID-19 Workplace Risk Assessment in place. A template has been developed by the Corporate H&S team to support managers for BCUHB wide communication and implementation. This is in addition to and compliments the All Wales COVID-19 Workforce Risk Assessment.

### **3.4 COVID-19 related Dangerous Occurrences reported to the Health and Safety Executive**

In 2020/21 there have been 13 COVID-19 related Dangerous Occurrences reported to the HSE under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

At the beginning of the pandemic advice from the HSE was to report staff clusters as a Dangerous Occurrence. The advice was later changed and the staff involved in these clusters were later reported individually as occupational diseases, this considerably increased the workload for the H&S Team.

*Annual break down of COVID-19 related Dangerous Occurrences reported under RIDDOR from April 1<sup>st</sup> 2020 – March 31<sup>st</sup> 2021*

Incident details	Total
Staff clusters reported as Dangerous Occurrences	4
Inappropriate PPE worn by staff or failure of PPE	7
Incorrectly packaged or stored coronavirus contaminated samples/equipment	2
	13

### **3.5 COVID-19 Sharps related incident reported to Health and Safety Executive**

In 2020/21, there has been one sharp related incident reported as a Dangerous Occurrence to the HSE under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). The appropriate Occupational Health management was followed and a Root Cause Analysis undertaken. The action implemented from this investigation was that an audit of compliance to the 'Insertion of a Central Line Checklist' will be undertaken. This action is ongoing.

### **3.6 HSE investigations 2020/21**

#### **3.6.1 HSE investigations Q4, Notification of Contravention**

On the 23<sup>rd</sup> of February 2021, the HSE issued a Notification of Contravention letter to BCUHB. This letter identified contraventions of health and safety law identified during an investigation the HSE undertook following a staff member who contracted COVID-19 and sadly passed away. Although it could not be confirmed where the staff member may have contracted COVID-19, material breaches were identified that BCUHB are now required to rectify. A Task and Finish group was established to primarily complete an action plan based on seven overarching recommendations. The requirements include implementing a recorded daily monitoring system to ensure that staff have had a fit test, that they are fitted to the mask they have available and that they understand what can impact the fit so they know when to have another fit test. A suggested way of completing this was to use Fit Test Identification Cards and a trial is due to start on the week commencing 19<sup>th</sup> of April in three departments across BCUHB. A further requirement is to ensure that the controls implemented following the completion of the COVID-19 Workforce Risk Assessment are suitable and sufficient. A response to the HSE is required on the 14<sup>th</sup> of April 2021.

### 3.6.2 HSE Improvement Notice

A RIDDOR report of a Dangerous Occurrence was sent to the HSE on the 28<sup>th</sup> of May 2020 relating to the partial failure of an FFP3 mask. This report led to an HSE investigation and subsequently BCUHB received an Improvement Notice on the 24<sup>th</sup> of August 2020. Details have been given in previous quarterly H&S reports but in brief the PPE Task and Finish Group undertook a significant action plan to completely change the Fit Testing Program in BCUHB. Fit testing is now only undertaken using the Quantitative method using PortaCounts, 18 had been purchased by the end of October 2020 and in March 2021 a further six were purchased. There is an interim Fit Testing Co-ordinator team in place and all fit testers have undertaken the Competent Fit Testers training by an Accredited Fit2Fit trainer. The Fit Testing Protocol has been written to replace the original guidance document and is due to go for final ratification in the Strategic Occupational Health Group in May 2021. Training for the fit testers is recorded on ESR and the work is progressing on recording all staff who have had an appropriate fit test on ESR as well.

The HSE have now confirmed that BCUHB have complied with the conditions set out in the Improvement Notice which relates to Ysbyty Glan Clwyd (YGC). The refitting of all staff in high risk areas was delayed due to the shortages of the 1863 respirator stock and no other viable alternative at that time. The stocks of the 1863+/9330+ are stable and there are enough to undertake the full refit program.

#### ▪ Additional HSE investigations

The HSE have requested information on three COVID-19 staff clusters during 2020/21 and reports were provided for these. The HSE have also undertaken an investigation into two staff members who contracted COVID-19 and sadly passed away. A full H&S investigation has been undertaken by the Corporate H&S Team and information passed to the HSE.

### 3.7 Datix incidents (Personal Injury)

A total of 2,309 incidents were reported in Q4 under the datix category 'Accident that may result in personal injury incidents'. The figures for COVID-19 related have marginally dropped in Q4 from Q3 along with the non COVID-19 related.

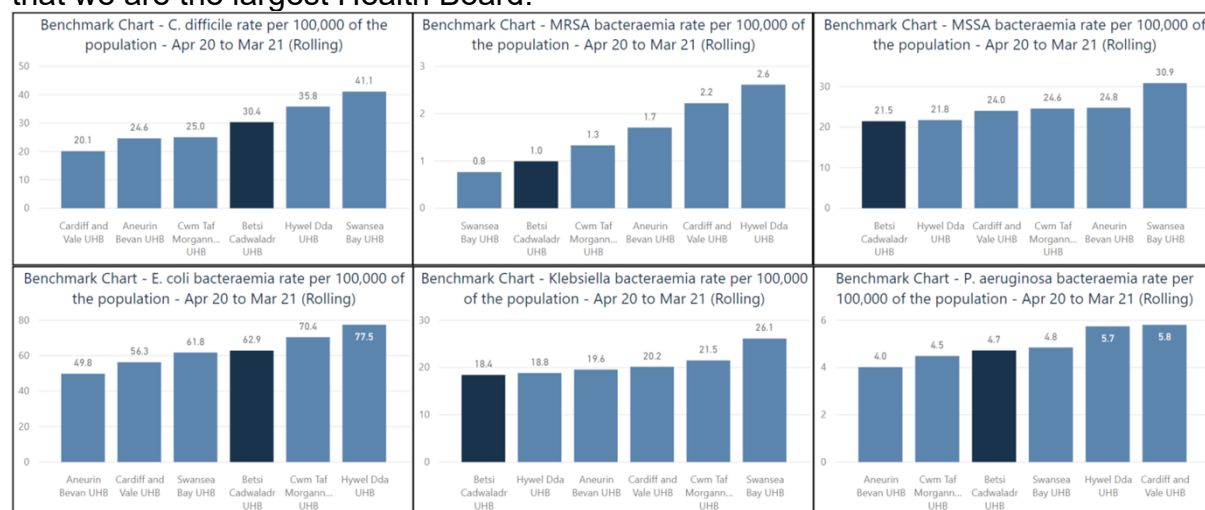
01.04.20 – 30.06.20 (Q1)	01.07.20 – 30.09.20 (Q2)	01.10.20 – 31.12.20 (Q3)	01.01.21 -31.03.21 (Q4)
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Total	2,122	1,867	2,260	2,309
Staff	770	431	791	733
	257 Non C19	301 Non C19	375 Non C19	331 Non C19
	513 C19 related	130 C19 related	416 C19 related	402 C19 related
Patients	1,328	1,403	1,432	1547
Other	24	33	37	29

## 4. INFECTION PREVENTION AND CONTROL

### ○ Overview

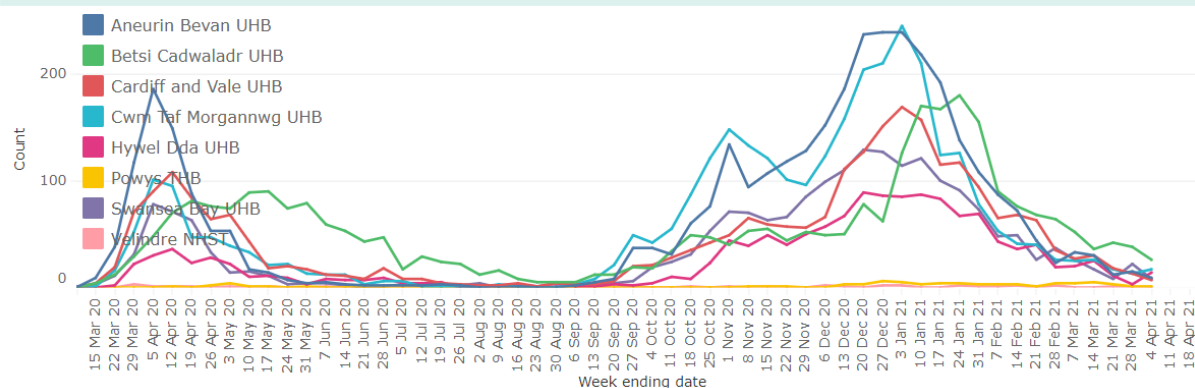
The charts below show the benchmarking position in respect of the range of infection indicators for all Welsh Health Boards. In comparison to other Health Boards, we are not an outlier. The BCU HB position is between first & fourth comparing data April '20 to March '21. It is also worth remembering that we are the largest Health Board.



## 4.2 Covid-19 cases comparison to March 2021

Community onset admissions have now fallen to low levels across all three areas & Covid related hospital occupancy is stable. Following review of the latest national modelling, it is anticipated that BCUHB occupancy will continue to track approximately 14 days behind the Most Likely Scenario during quarter 1 as per previous waves. Again based on experience of earlier waves, there is likely to be a differential in timing across North Wales of the peak in any future wave.

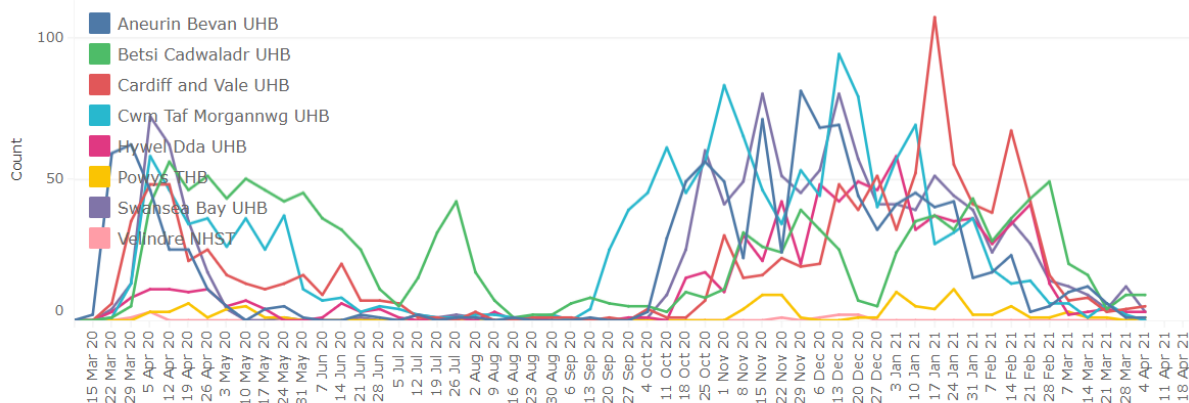
Weekly number of confirmed case admissions\* to all hospital wards, by health board of admission



### ○ Healthcare Associated Covid-19 comparison to March 2021

Hospital onset have now dropped to low levels, comparable with other Welsh Health Boards we are not an outlier. As soon as there is a Healthcare Associated Infection (HCAI) we need to ensure that any gaps in controls are closed on the wards.

**Weekly number of probable and definite hospital onset confirmed cases by HB**



### ○ Alert – Infection Prevention critical issues for escalation

- Corrective actions in place and assuring delivery around;
- Pseudomonas outbreak in East critical care
- Covid-19 outbreak within HMP Berwyn
- Enhanced Community Residential Services (ECRS) – Tawelfan H&S IPC joint review visit following the recent Covid-19 outbreak
- Covid-19 outbreak in west (Ysbyty Gwynedd – YG - and area still ongoing)
- Safe ventilation still an issue across a lot of our estate
- PPE communications is still mainly electronic and could not be reaching key personnel
- Not enough hand washing sinks across the Health Board in the right locations to support pandemic risk reduction
- Infection prevention controls need strengthening across the Health Board to prevent further outbreaks Round one has been received. We are planning to undertake a table top confirm and challenge meeting with each accountable area around their submitted evidence
- All accountable areas have been asked to reflect on their self assessment and strengthen their infection prevention plan on a page as required
- Key positions to support infection prevention e.g. Antimicrobial pharmacist, infection prevention team members recruitment still in process impacting upon specialist infection prevention support required across the Health Board, we need to retrieve our secondments or back fill rapidly
- Outbreak management is in place for YG to strengthen the controls
- Two care homes in the West experiencing significant increasing Covid-19 numbers causing concern IMT/IPC supporting in the west
- Increased linked case in one learning disability house, clear learning and actions in place
- Two mental health facilities increase in staff cases issues addressed re face masks and social distancing

### 4.4 Controls that need strengthening

The following have been identified as requiring further attention

- We need to have a IT solution for monitoring antibiotic use enabling rapid audit and escalation when off guidance

- an IT solution for tracking MRSA screening at front door and in hospital at 30 days & MSSA screening in our renal patients
- a Post Infection Review (PIR) database to support data capture, good governance and learning
- Junior doctors antimicrobials audits 'start smart then focus' needs strengthening as poor uptake to date
- 4 C antimicrobial high usage in the community need to develop a support plan to reduce over the coming months
- more isolation availability is needed particularly in our community hospitals, YG and Wrexham Maelor (WM) is a significant issue hampering our ability to keep our patients safe this has been added to the Board Assurance Framework
- decant areas to undertake routine Hydrogen Peroxide Vapour (HPV) cleaning to reduce bio burden across the health Board this has progressed through still need
- care bundles and risk assessments for patients completed and checked daily this needs to be reviewed daily to support completion
- PIRs to be undertaken rapidly within 72 hours to ensure safety and learning is quickly embedded
- reinforcement of Catheter appropriateness and management
- to develop regular monitoring around numbers and care bundle compliance

#### **4.5 Nosocomial Action Plan**

The Nosocomial Action Plan which gives a full update against actions agreed including building on lessons learned is included at Appendix 4.

#### **5. RECOMMENDATION**

The Committee is requested to note the position outlined in this report and provide comments on progress of the programmes.

## Appendix 1

### Vaccination programme – 1<sup>st</sup> dose

Priority Group	Cohort	Vaccinated	% Vaccinated	Booked	% Vaccinated & Booked	Unbooked
⊕	454		0%	44	10%	407
⊕ P1.1 - Older adult resident in ...	4,287	4,555	107%	1	107%	60
⊕ P1.2 - Care Home Worker	12,644	10,768	86%	113	87%	1,662
⊕ P2.1 - All those 80 years of a...	39,709	38,432	98%	44	98%	1,515
⊕ P2.2 - Health care workers	26,246	24,751	95%	78	95%	1,244
⊕ P2.3 - Social care workers	9,409	9,215	98%	36	99%	138
⊕ P3 - All those 75 years of age...	32,072	30,889	97%	118	98%	929
⊕ P4.1 - All those 70 years of a...	44,422	42,238	96%	636	97%	1,311
⊕ P4.2 - High risk adults under ...	17,265	16,022	94%	101	94%	1,054
⊕ P5 - All those 65 years of age...	36,939	34,037	93%	106	93%	2,274
⊕ P6 - Moderate risk adults un...	78,891	64,530	83%	883	84%	12,604
⊕ P7 - All those 60 years of age...	25,337	21,880	87%	278	88%	2,897
⊕ P8 - All those 55 years of age...	30,601	25,152	84%	849	87%	4,025
⊕ P9 - All those 50 years of age...	32,591	25,973	82%	1,489	86%	4,385
⊕ P10 - Rest of the population	204,040	24,573	12%	43,709	34%	135,161
<b>Total</b>	<b>594,907</b>	<b>373,015</b>	<b>64%</b>	<b>48,485</b>	<b>72%</b>	<b>169,666</b>





Table 2 – staff vaccinated with at least one dose by staff group and locality

		Priority Group 2 Frontline (DPC) workers			Priority Group 3 Non DPC staff 75 years and above			Priority Group 4 Non DPC staff 70 years and above Clinically Extremely vulnerable			Total Priority 2 - 4		
Region	Staff Group	Invited and vaccinated	Invited and Not Vaccinated	% Vaccinated	Invited and vaccinated	Invited and Not Vaccinated	% Vaccinated	Invited and vaccinated	Invited and Not Vaccinated	% Vaccinated	Vaccinated	Not Vaccinated	% Vaccinated
East	Add Prof Scientific and Technic	255	31	89.2%							255	31	89.2%
	Additional Clinical Services	1251	227	84.6%							1251	227	84.6%
	Administrative and Clerical	276	19	93.6%	1		100.0%	80	8	90.9%	357	27	93.0%
	Allied Health Professionals	358	38	90.4%							358	38	90.4%
	Estates and Ancillary	388	34	91.9%				7	1	87.5%	395	35	91.9%
	Healthcare Scientists	75	9	89.3%							75	9	89.3%
	Medical and Dental	408	85	82.8%							408	85	82.8%
	Nursing and Midwifery Registered	1753	239	88.0%							1753	239	88.0%
	Students	11	4	73.3%							11	4	73.3%
	<b>East Total</b>	<b>4775</b>	<b>686</b>	<b>87.4%</b>	<b>1</b>		<b>100.0%</b>	<b>87</b>	<b>9</b>	<b>90.6%</b>	<b>4863</b>	<b>695</b>	<b>87.5%</b>
Centre	Add Prof Scientific and Technic	256	35	88.0%							256	35	88.0%
	Additional Clinical Services	1220	157	88.6%							1220	157	88.6%
	Administrative and Clerical	300	31	90.6%	1		100.0%	93	2	97.9%	394	33	92.3%
	Allied Health Professionals	386	48	88.9%							386	48	88.9%
	Estates and Ancillary	493	53	90.3%	1		100.0%	13		100.0%	507	53	90.5%
	Healthcare Scientists	109	13	89.3%							109	13	89.3%
	Medical and Dental	508	106	82.7%							508	106	82.7%
	Nursing and Midwifery Registered	1828	205	89.9%							1828	205	89.9%
	Students	24	4	85.7%							24	4	85.7%



Table 3 - Demonstrates the numbers and percentages vaccinated by Division in priority groups 1 – 4

Staff Group	Priority Group 2 Frontline workers**			Priority Group 3 Non DPC staff 75 years and above			Priority Group 4 Non DPC staff 70 years and above Clinically Extremely vulnerable			Non DPC Invited (Age 55 and above)			Non DPC Not Invited			Total Priority 2 - 4		
	Invited and vaccinated	Invited and Not Vaccinated	% Vaccinated	Invited and vaccinated	Invited and Not Vaccinated	% Vaccinated	Invited and vaccinated	Invited and Not Vaccinated	% Vaccinated	Invited and vaccinated	Not Vaccinated	% Vaccinated	Vaccinated (validation underway)*	Not Vaccinated	% Vaccinated	Vaccinated	Not Vaccinated	% Vaccinated
Add Prof Scientific and Technic	776	91	89.5%													776	91	89.5%
Additional Clinical Services	3610	538	87.0%													3610	538	87.0%
Administrative and Clerical	793	87	90.1%	3		100.0%	240	13	94.9%	669	47	93.4%	1422	455	75.8%	1036	100	91.2%
Allied Health Professionals	1027	115	89.9%													1027	115	89.9%
Estates and Ancillary	1271	148	89.6%	1		100.0%	36	1	97.3%	71	3	95.9%	119	34	77.8%	1308	149	89.8%
Healthcare Scientists	250	34	88.0%													250	34	88.0%
Medical and Dental	1335	250	84.2%													1335	250	84.2%
Nursing and Midwifery Registered	5270	620	89.5%													5270	620	89.5%
Students	56	20	73.7%													56	20	73.7%
BCU - Bank	2459	821	75.0%	7	12	36.8%	27	20	57.4%	120	267	31.0%	124	1029	10.8%	2493	853	74.5%
Non BCU but working in BCU	616	463	57.1%													616	463	57.1%
	17463	3187	84.6%	11	12	47.8%	303	34	89.9%	860	317	73.1%	1665	1518	52.3%	17777	3233	84.6%
																860		
																18637		

\*\* Excludes 1344 DPC bank staff who have been invited but have not worked within the period October 2020 to December 2020

Table 4 Breakdown of all staff who have received 2 doses in the Health Board by Division

Priority Groups 1 to 4								
Type	Division	Vaccinated 1 Dose	Vaccinated 1 Dose %	Vaccinated 2 Doses	Vaccinated 2 Doses %	Not Vaccinated	Not Vaccinated %	Grand Total
BCU	Area Centre	193	9%	1740	81%	205	10%	2138
	Area East	157	7%	1748	81%	243	11%	2148
	Area West	124	8%	1196	82%	139	10%	1459
	MHLD	161	9%	1424	79%	221	12%	1806
	NWMCS	84	7%	962	84%	96	8%	1142
	Womens	54	7%	584	80%	96	13%	734
	YGC	156	9%	1386	77%	248	14%	1790
	YG	211	13%	1215	75%	185	11%	1611
	YMW	120	8%	1209	79%	195	13%	1524
	Estates and Facilities	147	11%	1097	79%	150	11%	1394
	Corp	72	11%	516	76%	94	14%	682
	NWSSP	10	6%	102	65%	45	29%	157
BCU - Bank		364	11%	2129	64%	853	25%	3346
Non BCU Students and External (Microbiology, PHW, Renal, Honorary etc)		172	16%	444	41%	463	43%	1079
Grand Total		2025	10%	15752	75%	3233	15%	21010

Table 5 - Black, Asian and Minority Ethnic Groups

Type	DPC List	Vaccinated	Not Vaccinated	Grand Total	
BCU	Yes	848	191	1039	
	No	23	21	44	
BCU - Bank		134	133	267	
Grand Total		1005	345	1350	
By Staff Group					
Type	DPC List	Staff Group	Vaccinated	Not Vaccinated	Grand Total
BCU	yes	Add Prof Scientific and Technic	22	6	28
		Additional Clinical Services	90	30	120
		Administrative and Clerical	4	2	6
		Allied Health Professionals	28	7	35
		Estates and Ancillary	30	6	36
		Healthcare Scientists	20	5	25
		Medical and Dental	450	101	551
		Nursing and Midwifery Registered	204	33	237
		Students		1	1
	No	Administrative and Clerical	22	20	42
		Estates and Ancillary	1		1
		Medical and Dental		1	1
BCU - Bank			134	133	267
Grand Total			1005	345	1350

Table 6 - Groups Vaccinated by Pay Band

<b>Pay Band</b>	<b>Vaccinated</b>	<b>Vaccinated %</b>	<b>Not Vaccinated</b>	<b>Not Vaccinated %</b>	<b>Grand Total</b>
Band 1	2	50%	2	50%	4
Band 2	5081	79%	1346	21%	6427
Band 3	2663	85%	461	15%	3124
Band 4	1221	84%	225	16%	1446
Band 5	3415	84%	657	16%	4072
Band 6	2864	89%	363	11%	3227
Band 7	1573	91%	156	9%	1729
Band 8a	524	89%	68	11%	592
Band 8b	174	88%	24	12%	198
Band 8c	119	92%	10	8%	129
Band 8d	53	87%	8	13%	61
Band 9	24	86%	4	14%	28
M&D/Non AfC/Ad Hoc Grades	1861	60%	1237	40%	3098
Non BCU	616	57%	463	43%	1079
NWSSP	112	72%	44	28%	156
<b>Grand Total</b>	<b>20302</b>	<b>80%</b>	<b>5068</b>	<b>20%</b>	<b>25370</b>

## **Appendix 3**

### **Testing Strategy Summary**

Welsh Government (WG) published the first Testing Strategy on 15 July 2020. Since that time, testing has continued to play a pivotal role in our overall approach to preventing the transmission of Covid-19 across Wales. As knowledge has grown and technologies developed, a revised Testing strategy for Wales was published on 28<sup>th</sup> January 2021.

The strategy outlines that testing on its own does not remove or reduce the extent to which the virus is circulating in communities. Everyone, irrespective of whether they have had a test recently must maintain social distancing where possible, practise good hand hygiene and follow the guidelines on the wearing of face coverings in order to keep us all safe.

Testing can play a part in reducing the harms associated with Covid-19 and since the first strategy was published, new testing technologies have demonstrated it is possible to test at far greater scale, frequency and speed than previously. Testing will continue to play an important role alongside the vaccine in supporting us to save lives and livelihoods during 2021 and the longer term.

The harm caused by Covid-19 is not limited to the direct harm caused to those who become infected. Harm also arises when the NHS and social care systems are overwhelmed; when other non-Covid related activities are reduced; and as a result of wider societal actions such as lockdown. The revised testing strategy aims to minimise or alleviate these harms wherever possible.

In addition to using testing to diagnose and identify Covid-19 to help with treatment and to support contact tracing, thereby reducing the spread of the disease, new testing technologies offer the potential to adopt our approaches to testing. These should enable individuals to continue to receive in person education and to work, and this will help to maintain key services when the prevalence of the virus is high. Tests are now used across a variety of settings including hospitals, test sites, care homes and mobile testing units. Alongside the vaccination programme, testing will also support the safe return to normal society and economic activity.

The testing priorities remain the same:

1. To support NHS clinical care – diagnosing those who are infected so that clinical judgments can be made to ensure the best care.
2. To protect our NHS and social care services and individuals who are our most vulnerable.
3. To target outbreaks and enhance community surveillance in order to prevent the spread of the disease amongst the population.
4. Supporting the education system and to support the health and well-being of our children and young people, and to enable them to realise their potential.
5. Identifying contacts of positive cases to prevent them from potentially spreading the infection if they were to become infected and infectious, and to maintain key services.
6. To promote economic, social, cultural and environmental wellbeing and recovery.

In summary the approach going forward, will be:

- Test to diagnose
- Test to safeguard
- Test to find
- Test to maintain
- Test to enable

## **1. Test to diagnose**

The aim is to identify patients who are infected/infectious as quickly as possible, particularly those presenting to hospital so that they may benefit from specific treatment for Covid-19.

A confirmed diagnosis is also important to reduce uncertainty and the need for further investigations. In this context a highly sensitive and specific test is required. Any test result should be interpreted in the clinical context and further testing directed as necessary.

Our testing strategy moving forward will continue to focus on supporting people receiving care and or being admitted to hospitals.

## **2. Test to Safeguard**

Covid-19 is a challenge in closed settings such as hospitals, care homes and prisons because it can be difficult to control the spread once infection is introduced. The risk of infection being brought into a closed setting is related to the prevalence of infection in the community, therefore greater vigilance is needed when prevalence within the population is higher.

Infected individuals may enter closed settings as symptomatic or asymptomatic residents, visitors, or staff members. The primary measures to control risk of infection are the use of appropriate Infection, Prevention and Control procedures. Testing can provide some additional safeguards but cannot be used as a sole means of control.

Symptomatic staff, wherever they work, should self-isolate and request a test. Testing of asymptomatic staff working with vulnerable people, especially within closed settings, can potentially identify infected/infectious individuals who might otherwise pose a risk. It is recommended asymptomatic testing using lateral flow tests is undertaken at a minimum of twice per week.

In December 2020, the Welsh Government (WG) published a detailed control plan for social care to assist social care services and the public in understanding the measures in place to protect the most vulnerable individuals in Wales. This document sets out the testing that should be in place for staff at different levels of prevalence, and how to minimise the risk when allowing visitors and external care staff into the home.

Subject to supply, the aim of WG is to offer Covid-19 vaccination to all care home residents and staff; frontline health and social care staff; those 70 years of age and



over; and clinically extremely vulnerable individuals by mid-February. Whilst this is incredibly positive, testing must remain in place for the foreseeable future. This is because the evidence is not yet available to determine whether vaccination reduces the risk of the virus being transmitted to others.

With this in mind our approach to 'testing to safeguard' currently involves asymptomatic testing of:

- *NHS staff* - Testing of asymptomatic staff can potentially identify infected/infectious individuals who might otherwise mix within the hospital. This is in the process of being rolled out across the Health Board.
- *Care home staff* - Testing of asymptomatic staff can potentially identify infected/infectious individuals who might otherwise mix within the care home. This is in progress of being rolled out.
- *Supported Living staff* - Testing of asymptomatic staff visiting vulnerable people can potentially identify infected/infectious individuals who might otherwise expose the vulnerable individuals they visit. This is being explored.
- *Special school staff* - Testing of asymptomatic staff working with vulnerable people can potentially identify infected/infectious individuals who might otherwise expose the vulnerable individuals they work with. This will be in place from 22 February 2021 unless a school has opted out.
- *Domiciliary care staff* - Testing of asymptomatic staff visiting vulnerable people can potentially identify infected/infectious individuals who might otherwise expose the vulnerable individuals they visit. This is being explored.
- *Staff working in other residential care and support settings* – Testing of asymptomatic staff visiting vulnerable people can potentially identify infected/infectious individuals who might otherwise expose vulnerable individuals. This is being explored.
- *Prisoners* - Any prisoners who develop symptoms should be tested. All new arrivals should be tested on admission. This test should have high sensitivity and specificity (e.g. RT-PCR); the impact of false negative results could be significant due to the difficulty in controlling spread. This is in place.
- *Care home residents* - Any residents who develop symptoms should be tested. Admissions from the community or from hospitals or other closed settings should be tested prior to admission. This test should have high sensitivity and specificity (e.g. RT-PCR); the impact of false negative results could be significant due to the vulnerable nature of the residents and the setting, and therefore these should be minimised. This is in place.
- *Visitors* -
  - Symptomatic individuals who might be visitors should self-isolate and order a test. They should not visit a care home. This is in place.
  - For asymptomatic visitors, the main control measure is reduced social mixing for the 7-14 days prior to visiting. Testing can provide reassurance that a visitor is not infected/infectious at the time of the visit. This is in progress.
  - Professional visitors should be tested prior to attending a care home. If they are part of a regular testing programme (e.g. under the NHS testing programme) they will not need to be tested again prior to entry. If professional visitors are not part of a regular testing programme, they should be tested at the time of the visit. This is in place.

### 3. Test to Find

Identifying and isolating Covid-19 cases in the community reduces the transmission of infection and helps to slow or stop the spread of the disease. Reduced prevalence of infection in the community reduces the number of severe infections, protects vulnerable individuals, protects the NHS, and reduces mortality.

Everyone who thinks they have symptoms of Covid-19 should get a test. There are now a number of channels people can access testing through, including a network of testing centres with more planned for 2021, making testing for Covid-19 more accessible than ever before.

Our testing sites include:

- Regional Testing Sites (RTS) – provide drive through facilities. North Wales has access to two facilities based in Deeside and Llandudno
- Local Testing Sites (LTS) – provide walk in facilities. North Wales has four facilities based in Wrexham, Connah's Quay, Rhyl and Bangor.
- Mobile Testing Units (MTUs) – can provide flexible facilities to increase accessibility and to focus in areas of need. There have been four MTUs operating across North Wales. Three additional units are in the process of being deployed across the region
- Home testing – for people to have tests posted to them to take at home

Given that 40% of people may have mild or no symptoms, there are certain contexts in which there may be a need to deploy more active case finding approaches such as those trialled in Merthyr and Lower Cynon where whole area testing was undertaken during late November and December 2020. A Community Testing plan is currently being developed in partnership between the Health Board and Local Authorities for North Wales

### 4. Test to Maintain

On average 10% of contacts develop Covid-19. Currently, contacts of infected individuals are required to self-isolate for 10 days. While this strategy should effectively remove potentially infected/infectious contacts from mixing and potentially transmitting infection, it has a number of potentially negative impacts:

- Workforce pressures, especially at times of high Covid-19 prevalence. This is particularly important for critical workers (health, social care, category 1 responders and others)
- It creates economic pressures on key businesses that impact on critical supplies and those affected who may lose income
- It negatively impacts on the health and well-being of contacts having to isolate
- And of particular concern, large numbers of children and young people miss out on face to face education

Therefore, there are a number of tests for asymptomatic contacts being explored to potentially allow them to remain in work or education as an alternative to isolating for 10 days. Daily testing for the 5-7 days from identification as a contact could reduce the risk that a person attends work or education while infected/infectious.

Whether this type of daily contact testing can or should be adopted will be dependent on whether the individuals concerned work with vulnerable people, and whether they work within a closed setting. This is because the daily test only gives a snapshot of infectivity at the time of the test. This strategy will not be appropriate where the repercussions arising from a false negative could be very serious.

## **5. Test to enable**

As the vaccine roll out moves forward and towards a lower prevalence of the virus, later in 2021, WG have signalled that they will look to see how testing can further support a return to normality and meet our sixth testing priority - to promote economic, social, cultural and environmental wellbeing and recovery.

Further work and approval of the testing approach and processes will be required to fully deliver Test to Enable.

A number of the above initiatives are led and enabled by the Health Board testing team whilst others are led centrally by WG. The expansion of the testing service is extensive and it is anticipated will be required for several months, if not years, to come. The Testing Team has been agile and adapted to increases in demand and rapid changes to implement new technologies. There is a significant amount of work still to do and the resources to support are under review.

### Nosocomial Action Plan

<b>Date: 21 March 2021</b>	<b>Version: 15</b>	<b>Authors: Debra Hickman/Sally Batley SRO: Gill Harris</b>
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Issue	Action	SRO	Start Date	Completion Date	Update	RAG status
1.Compliance with the WG 16 point plan / toolkit	1.0 Reissue intranet links / previous reports related to outbreak learning across the HB to all HMT's reaffirming Leadership and Accountability	DH Support - GA	5 <sup>th</sup> March 2021	5 <sup>th</sup> March 2021	Sent – receipt acknowledged	
	1.1 Issue Self-assessment to all sites based on the WG 16 point plan	SB Support - GA	12 <sup>th</sup> March 2021	22 <sup>nd</sup> March 2021	Completion 22 <sup>nd</sup> March 2021 All received – currently being reviewed by SB to inform SRO work streams <b>2/4 – Assessments have been cross referenced with Site plans for 21/22 Reassessment date TBC</b>	
	1.2 Independent review of YG outbreak to have clear TOR approved by Board and reported back via QSE upon completion	CH	12 <sup>th</sup> March 2021	<b>3<sup>rd</sup> May 2021* will need confirming once reviewer identified</b>	External reviewer identified. TOR drafted for Executive <b>and Board approval</b> . TOR finalised with independent	

					reviewer, review underway 2/4 Current review ceased. TOR to be amended following receipt of further comments from IMs & Chairman. New reviewer to be identified – request sent to WoD	
	1.3 Review Intranet to ensure all current COVID guidance accessible / remove out of date documents	AL	12 <sup>th</sup> March 2021	5 <sup>th</sup> May 2021*	In progress	
	1.4 Complete revision of remaining out of date policies <b>and disseminate revised policies</b>	AL/SF	1 <sup>st</sup> February 2021 (work already in progress)	30 <sup>th</sup> April 2021*	Review complete, remaining policies under review. Chairs action taken where applicable for approval, some will require QSE approval 2/4 a number of policies are now on the intranet for consultation	
	1.5 Strengthen Nursing compliance audits <b>across all sites /areas</b>	RC	16 <sup>th</sup> March 2021	15 <sup>th</sup> April 2021	commenced	
	Develop audit program for non-clinical areas <b>across all sites /areas</b>	SB/RT	Existing work – in progress Jan 2021	22 <sup>nd</sup> April 2021*	Commenced C4C audits in place COVID checklists in place – review required regards consistency. Self-	

					assessments to inform areas of focus.	
	1.6 Review current monitoring and review processes linked to IPC05 outbreak management 1.7 policy – including the <b>Healthcare Acquired Infection panels</b> and OCT fora.	SB/CD	12 <sup>th</sup> March 2021	2 <sup>nd</sup> April 2021	Existing review completed and draft report received. TOR reviewed regards Harm review panels OCT TOR to include LA coverage and PHW LA input completed by AL <b>2/4 as per 1.4</b>	
	1.8 Strengthen IP expertise and resource – considering Office of the Medical Director and Pharmacy colleagues	AG/SB	10 <sup>th</sup> March 2021	15 <sup>th</sup> April 2021	Additional support provided to YG by Deputy IP lead Further external support requested via WoD <b>2/4 nil received via WoD</b> <b>YG Walk around and site presence continues to be supported by Deputy IP lead &amp; SCDON minimum weekly</b>	
	1.9 Develop a Board assurance framework underpinned by the WG CNO / CMO 16pt plan	SB/DH	10 <sup>th</sup> March 2021	9 <sup>th</sup> April 2021 *	Working Example received. Discussed via IPSG 23/3/21 <b>2/4 in development and draft to be shared with QSE</b>	

	1.10 Ensure clear mechanisms for inclusion of Test Trace Protect learning is formally reported via OCT's / IPSG and is included via the safe clean care programme	TO	22 <sup>nd</sup> February 2021	28 <sup>th</sup> March 2021	TTP to be added to the TOR for OCT within ICP05 - completed TTP added to the IPSG membership – completed. Invites sent for future IPSG meetings	
2. Embedding of learning and practices to ensure sustainable zero tolerance to patient Harm as a result nosocomial transmission <b>across all clinical areas</b>	2.0 Revision of the COVID Delivery work plan to outline the 3 x 90 day targeted work programmes for the following learning themes: Safe space, safe place, safe action incorporating Reinforce implementation of single point of Access / Egress, access challenge, Signage, Environmental issues, Deep Clean programmes, Bed spacing, behaviours and adherence to basic IP practices as examples	<b>SRO 's agreed:</b> <b>DH</b> <b>KC</b> <b>GM</b>  <b>Deputies to be confirmed</b>	Mid-June 2021	Mid-June 2021*	Kick off meeting with SROs 10 <sup>th</sup> March 2021 Work programmes to be detailed as per learning and teams to be confirmed as 16 <sup>th</sup> March. Initial draft plans prepared – SRO meeting to discuss 24/3/21 Weekly Board update process to be agreed 23/3/21 <b>2/4 update report to be provided to QSE</b>	
	2.1 Develop capacity for targeted support of above work programmes with behavioural change / psychology/ PMO / Analytical expertise	DH/GA	12 <sup>th</sup> March 2021	28 <sup>th</sup> March 2021	<b>2/4 Analytical support – to be discussed at SRO meeting 7/4 as only limited support now available</b> SI support confirmed PMO support confirmed.	

	2.2 Review TOR for the Safe clean care steering group and reporting sub groups across <b>acute and community sites</b>	RC/SB	12 <sup>th</sup> March 2021	12 <sup>th</sup> March 2021	completed	
	2.3 Review assurance/governance mechanisms to ensure sustainability / ongoing reporting aligned with HB governance framework	SB	Existing IP work programme – review commissioned Dec 2021 / commenced Jan 2021	28 <sup>th</sup> April 2021*	Existing review completed and draft report received. Meeting convened with QSE & PSQ chair to review.	
	2.4 Review of complaints / incidents related to nosocomial transmission	MJ	12 <sup>th</sup> March 2021	15 <sup>th</sup> April 2021	Request made <b>2/4 data received – analysis underway to share with SROs and inform work programmes as required as per 2.4</b>	
	2.5 Undertake active patient feedback to inform ongoing improvements	MJ	22 <sup>nd</sup> March	28 <sup>th</sup> April		
3. Absence of an Alert System	3.0 Development of Harm & IP dashboards	SB	16 <sup>th</sup> March	28 <sup>th</sup> May 2021*	Harm Dashboard created to support PSQG. Enhanced IP dashboard requirements to be confirmed by 6/4/21 to inform build time <b>2/4</b>	
	3.1 Development of process for escalation including triggers	SB	Existing work – in progress Feb 2021	15 <sup>th</sup> April 2021*	Linked to the above	



4.Consistency of Communication	4.0 Review current channels of communication	Comms	12 <sup>th</sup> March 2021	1 <sup>st</sup> April 2021	Comms lead identified – review underway 2/4 comms plan developed and shared with SROs 31/3 for comments to be confirmed 7/4	
	4.1 Review / update current messaging in line with revised toolkit	Comms	12 <sup>th</sup> March 2021	15 <sup>th</sup> April 2021	As above	
	4.2 Develop a communication plan that supports the work program and is consistent with HB values	Comms	12 <sup>th</sup> April 2021	15 <sup>th</sup> April 2021	As above as per 4.0	
	4.3 Review of communication process for Patients / NOK where nosocomial transmission has resulted in harm ensuring it is reflected in policy	MJ	1 <sup>st</sup> April 2021	15 <sup>th</sup> April 2021	Awaiting National framework release	
	4.4 Review and strengthen operational escalation processes in line with IP triggers and escalation requirements	GM/MW	22 <sup>nd</sup> March 2021	28 <sup>th</sup> April 2021*	Awaiting IP trigger confirmation 2/4 as per 2.4	
	4.5 Update the wider Board twice weekly on Tuesday and Thursday of outbreak performance escalating issues of concern or areas of improvement	GH	7 <sup>th</sup> March 2021	16 <sup>th</sup> March 2021	commenced	
5 Staff Wellbeing	5.0 To provide support and access of wellbeing services across the HB, particularly in areas of concern. A review of the model has been undertaken and clear access to staff support for their mental health and psychological wellbeing is being implemented along with the current counselling and psychological services, to ensure access to different needs of support at particular times is implemented. Further work on the overall wellbeing strategy is taking place once the above key element is implemented.	EG PB SWJ	16 <sup>th</sup> March 2021	31.4.21*	Awaiting Business Case review 2/4 business case still in draft – date extended	

6. Vaccination	6.0 To review vaccination uptake in all areas ensuring evidence of information provision and professional conversation	AG/GH	18 <sup>th</sup> March 2021	15 <sup>th</sup> April 2021*	Data being shared with Sites/Areas	
	6.1 Review the deployment process of staff in high COVID burden areas where vaccination is noted to be a gap using a risk assessment approach	SG/GH	18 <sup>th</sup> March 2021	31 <sup>st</sup> April 2021*	Discussion to be had with WoD and Staffside colleagues.	
7. Antimicrobial Stewardship	7.0 Review antimicrobial coverage stewardship across the Health Board ensuring representation across all areas/sites	BO	12 <sup>th</sup> March 2021	30 <sup>th</sup> April 2021	Review Completed & presented at IPSG 23/3/21	
	7.1 Report non-compliance via IPSG of any areas/sites within the HB and clear improvement plans to address	BO	12 <sup>th</sup> March 2021	30 <sup>th</sup> April 2021	Revised assurance reports piloted via IPSG	

\*subject to change



<b>Cyfarfod a dyddiad: Meeting and date:</b>	Quality, Safety & Experience (QSE) Committee 4 <sup>th</sup> May 2021						
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public						
<b>Teitl yr Adroddiad Report Title:</b>	Mental Health and Learning Disabilities Division receipt of and actions from the "Review of the Discharge of Mental Health Patients During the Covid-19 Pandemic"						
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Teresa Owen, Executive Director for Public Health and Executive Lead for Mental Health and Learning Disabilities (MHLDD)						
<b>Awdur yr Adroddiad Report Author:</b>	Mike Smith, Interim Director of Nursing Mental Health and Learning Disabilities Iain Wilkie, Interim Director for Mental Health and Learning Disabilities						
<b>Craffu blaenorol: Prior Scrutiny:</b>	Divisional Directors Mental Health and Learning Disabilities						
<b>Atodiadau Appendices:</b>	None						
<b>Argymhelliad / Recommendation:</b>							
The Committee is asked to note:-							
<ol style="list-style-type: none"> <li>1. That the division fully accepts both the findings and recommendations of the report</li> <li>2. That the division has considered and stated its learning from the report</li> <li>3. That the division has stated its actions to prevent recurrence both tactically and strategically as it plans its next steps.</li> </ol>							
Please tick as appropriate							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>	x	<b>Er gwybodaeth For Information</b>	
<b>Y/N to indicate whether the Equality/SED duty is applicable</b>							<b>N</b>
<b>Sefyllfa / Situation:</b>							
To provide a written update to the BCUHB QSE upon the receipt and consideration of the "Review of the Discharge of Mental Health Patients During the Covid-19 Pandemic" by the MHLDD Divisions QSE, the divisions learning from this report and assurances to the QSE to prevent recurrence.							
<b>Cefndir / Background:</b>							
This report was requested as an update to prior QSE actions.							

**Strategy Implications**

This report influences and informs the development of the MHLD divisions next phase plan

**Options considered**

Options are not considered within this report

**Financial Implications**

A financial assessment has not been included within this exception report.

**Risk Analysis**

The report is an analysis of the discharge of patients from mental health services and actions to prevent recurrence

**Legal and Compliance**

This report provides data on assuring compliance with the MHM part 1a and 1b during subsequent waves of the Covid 19 Pandemic.

**Impact Assessment**

There are no proposed service changes within this report, although there will be, as a result of this report, a review of the divisions' management and senior operational delivery structure, if there is a change proposed from this review there will be a full EQIA.

## **Mental Health and Learning Disability Services**

### **1.0 Purpose of report**

To provide a written update to the BCUHB QSE upon the receipt and consideration of the “Review of the Discharge of Mental Health Patients During the Covid-19 Pandemic” by the MHL D Divisions QSE.

The update also includes the divisions learning from this report, and information to assure QSE regarding preventing recurrence.

### **2.0 Mental Health and Learning Disabilities Priorities**

1. Stronger and Aligned Management and Governance
2. Review of Capacity and Capability
3. Delivery of Safe and Effective Services in Partnership
4. Engagement with Staff, Users and Stakeholders

### **3.0 Situation**

This was a review into the actions of the MHL D division in March/April 2020 of the “Incorrect discharge of patients from Primary Care Mental Health Services”

The report was presented to the Divisional QSE by the Interim Director of Nursing MHL D in December 2020.

### **4.0 Background**

During 2020, the NHS and care sector as a whole, faced unprecedented challenges, as services responded to the impact of the COVID19 pandemic.

From March 2020, the Mental Health & Learning Disabilities (MHL D) Division of the Health Board responded to this challenge rapidly and established a ‘command and control’ governance structure to meet the constantly changing situation.

In these earlier phases of the pandemic, national and internal guidance and instruction was being rapidly developed, updated and distributed.

In late March and early April 2020, high numbers of Primary Care Mental Health (PCMH) patients were discharged incorrectly from the Health Board’s MHL D services. This was led by the area mental health teams, following interpretation of an instruction they had received from the MHL D Control Centre, with an expectation that this would allow the redeployment of primary care mental health staff to support more vulnerable mental health patients. Each area mental health team implemented the action.

Concerns regarding this action were raised by local GPs and by Welsh Government during the first two weeks of April 2020, with further national guidance being issued around this time.

#### **4.0 Analysis**

The incident that has been reviewed occurred during the early stages of the pandemic, at a time that the NHS was working in a very fast changing environment; the projected numbers of Covid-19 patients was significant and all services had to make quick decisions to ensure the sustainability of essential services, with potentially reduced numbers of staff.

The review focused on the incorrect discharge of Primary Care Mental Health (PCMH) patients in March/April 2020. Care for this cohort of patients falls under Part 1 of the Mental Health (Wales) Measure; a law passed by the National Assembly for Wales in 2010 and, as such, has the same legal status in Wales as other Mental Health Acts. However, whilst the earlier Mental Health Acts are largely about compulsory powers, and admission to or discharge from hospital, the 2010 Measure is about the support that should be available for people with mental health problems in Wales wherever they may be living.

The review summarised with the following key findings:

1. The incident reviewed occurred during the first phase of the Covid-19 pandemic, during an intense period of planning and necessary service change.
2. All related actions taken, which led to the incorrect discharge of PCMH patients, and subsequent reinstatement of patients, were made with good intention to follow instruction and also support the most vulnerable patients. All staff interviewed as part of this review demonstrated a concern for putting patients first.
3. There were several examples of confusion caused from unclear communication and instruction, with some disconnect between divisional directors, and the senior managers and local area mental health teams; this may have been avoided if the proposed MHLD Covid-19 Operational Group had been established at the time of the incident.
4. The inconsistent use of terminology used to describe the Part 1 MH services across the division and with key stakeholders may have added to the confusion;
5. There appears to have been an avoidable delay from when concerns were raised regarding the discharge of PCMH patients to the actual reinstatement of the service. It appears that this was mainly due to unclear communication;
6. The concerns were not captured in real time in the MHLD RAID log and were not then escalated to Health Emergency Control Centre (HECC) Gold Command;

7. All individuals who have contributed to this review provided assurances and clarity that no significant patient harm was caused.

### MHLD Divisional Response

#### **The MHLD Division accepts the findings of the report in full.**

The MHLD Division had significant absence in its senior managerial structure early in the year, some of it longstanding. This was compounded by absences elsewhere at senior level within the three areas of operations. This continued and accelerated through the early planning phases of the pandemic response. This left a small number of people in the division able to act and very limited depth of support to this small group.

National Guidance issued from Welsh Government in March 2020 was “high level”, was being locally translated, and interpreted, however MHLD had already begun to plan and prepare clinical pathways approaches early in the year.

An instruction was made from the Mental Health Divisions “Clinical Reference Group”, to prepare the division to release resource to prioritise and focus support to the “most vulnerable” and to increase staffing availability. This was interpreted in the area management of the Mental Health Division as advising them to consider the reduction of the function of its Primary Care Mental Health services (which are the part of the division that receive new referrals from primary care and assess, screen and direct those in need to appropriate treatments or signpost to other supports available except in cases for urgent or emergency that they escalate) and to discharge patients currently in the services, although this varied in both nature and degree across the 3 areas of operational delivery in MH services.

All patients affected were risk assessed and those deemed vulnerable were not discharged, some being referred to MH secondary care services. All patients that could be, were directly contacted by MHLD workers and advice was given on where they could get help and how to contact MHLD workers if their situations changed.

There was an inconsistent interpretation in each of 3 areas, although all did discharge some patients to create capacity. Links to area management within MHLD appeared disconnected and stressed at this time due to the capacity issues outlined elsewhere. There was minimal capacity to cope with the surge of activity, people absent or out of position and multiple roles being covered by small number of individuals.

“It was confirmed that” every patient referred and discharged was provided with advice and information on how to contact MHLD staff if necessary and that in most cases direct contact was made with the referred person by the LPMHS staff to discuss this with them.

Concerns were quickly raised from GP’s and others from early April regarding these discharges and the availability of support. The MHLD division began to reverse the



actions were implemented and apologised, although even this action appeared disconnected and protracted.

Restoration of LPMHS was unclear and slow (Mid. April through to 3<sup>rd</sup> June), however once a clear position in the MHL D division was affirmed in late May and applied across all 3 areas, there was assurance that all patients affected had been contacted and a service reinstated for each individual where appropriate. This consumed significant time and resource in the 3 areas.

There were also significant other issues rising in the division through this time period, most notably the significant staff concerns regarding service changes impacting in the East, resulting in a series of whistle blowing events that were responded to swiftly. There were also significant safeguarding concerns regarding the Heddfan unit existing since January 2020 that had escalated to a “service of concern” with the Local Authority, resulting in a Healthcare Inspectorate Wales (HIW) inspection and significant scrutiny from the wider Health Board, and subsequent support to the division.

#### Review Recommendations and Divisional Response

**The MHL D Division accepts the review recommendations in full.**

***Recommendation 1. To reconsider the MHL D Division governance structures, including how area mental health teams work together as one service, to ensure common understanding, and service delivery processes.***

Restoration of the Divisional Senior Leadership Team has been achieved in all but one role (Divisional Head of Psychology). The addition of two interim Deputy Directors leading on partnerships and engagement, workforce issues, governance alignment and Covid/winter planning ensures a strengthened divisional senior leadership team in line with the Q3-Q4 Operational Plan.

The governance team of the division has been integrated into corporate governance and handed over formally in December 2020, further integration discussions and work continues with corporate colleagues as and when appropriate. The division has successfully moved to the new corporate risk approach which is now being embedded and all Terms of reference have been amended to reflect corporate approach.

Clinical Governance has been strengthened with the Clinical Advisory Group (CAG) the centre of clinical advice and recommendation within the Division. Heads of Operations are in attendance and wider professional attendance is actively encouraged. CAG will make recommendations to the Senior Leadership Team/Gold Command for consideration and action ensuring that the Division does not act unilaterally and without due consideration of the impact of decisions upon patients and our partners.

The Division is strengthening the link between Divisional Management and Area Triumvirates through the process of regular formal and planned Senior Leadership meetings with area Clinical Directors, Heads of Operations, Heads of Nursing,

Governance and Directors. This mechanism ensures the link between the Divisional Senior Leadership Team, Programme Leads, Operational Leads and other Heads of Service (Psychology) and Governance is robust. This ensures common understanding and aligned service delivery processes and is in line with the Divisional COVID19 Winter Plan.

***Recommendation 2. To refresh and improve communication processes in the division to better support a two way flow of information, ideas, suggestions and decision making between the directors and the operational area mental health teams.***

The Division is making headway in strengthening the communication between the Divisional Directors and Triumvirates to ensure that information sharing and decision making is collaborative and a two way process. The weekly COVID 19 Senior Leadership meeting, improved CAG membership and Pathway Development Groups provide the appropriate forums for communication, engagement and planning for the delivery of decisions approved by the Divisional Directorate.

All communications in relation to COVID 19 are cascaded through each of the Heads of Operations ensuring there are clear lines of communication and coordination within areas.

The Q3/4 Plan identified that Fortnightly staff briefings were embedded across the Division to ensure that all staff are aware of issues, updates and service plans.

All written public facing communications will be managed by the Divisional Leadership Team and will be signed off by the Divisional Director or nominated delegate. To complement this, weekly “Keep in Touch” calls will be undertaken by the respective Head of Operation’s (HoPs) with the Local Authority Leads for their Locality. A timeframe will be agreed with the Divisional SLT for communication updates with other partners i.e. Community Health Council (CHC), Advocacy, and the Area Planning Board, using existing forums where appropriate

***Recommendation 3. To agree and adopt common terminology for primary care and community mental health services across the MHLD division, Health Board and key stakeholders.***

A multi-disciplinary Community Pathway Group has been established to revise the Community Mental Health Team policy and associated Standard Operating Procedure in relation to Primary and Secondary Care. This will include the review of terminology for Primary Care and Community Mental Health Services to ensure consistency across the region.

The Pathway Group was paused during the COVID-19 tactical response period however plans are in place to re-establish and for renewed focus and reporting.

***Recommendation 4. To ensure a clear definition of roles and responsibilities across primary care and community mental health services, with consideration as to the need for consistent management structures and roles across the area mental health teams.***

In addition to the above work stream, the Community Pathway group in partnership with the Area Team and cluster colleagues will clearly define how Community Mental Health services will be delivered in the future and the associated integrated management structures to support.

Following the Joint Thematic Review of Community Mental Health Teams (Healthcare Inspectorate Wales and Care Inspectorate Wales 2019), the MLHD are currently undertaking a baseline review of current services that will inform this programme going forward

***Recommendation 5. To develop engagement processes and joint working across the MHL D division, ensuring a better understanding of decision-making and accountabilities.***

The Division has maintained robust oversight and scrutiny of both clinical and non-clinical activities throughout the Covid-10 pandemic via its tactical Command structure.

Governance processes including communication and engagement across the MHL D Division have been established to ensure better understanding of decision making and accountabilities.

The Division is now in the process of standing down the command structure to return to business as usual with robust governance arrangements to ensure safe and effective delivery of services.

***Recommendation 6. To improve engagement and collaborative working between the MHL D division and clusters, with local area mental health teams sharing their current practice and suggestions.***

The Together for Mental Health Partnership Board has been re-established and is in the process of reviewing its terms of reference and planning a refresh of the Together for Mental Health Strategy with partners which will include our Cluster colleagues. This process will be supported by evidence from the outcome of the North Wales population needs assessment.

Opportunities to work closely with Area Teams and Local Authorities have been established by regular attendance at Area Integrated Service Boards and also via the North Wales Leadership Group. Further work is required to establish formal reporting functions to Clusters although there has been during the latter part of 20/21 been regular informal reporting into Cluster meetings from the Division.

We will continue to develop our relationships with Clusters across the region and our 3 year Transformation programme has a particular focus in enhancing the Mental Health Offer into Clusters, and the team are working with Community Transformation Leads and Cluster Leads to develop and implement.

***Recommendation 7. To review the Part 1 Mental Health Measure (MHM) model of care in North Wales, to include engagement with the three Area Divisions, clusters and other key stakeholders.***

A review of Part 1 MHM Model is required and will form part of the Community Pathway programme of work. This work has not yet commenced.

***Recommendation 8. To review all Datix entries relating to PCMH patients made between 23rd March 2020 to 3rd June 2020 as further evidence as to whether any patient harm was caused.***

A Divisional review commenced in September 2020 of patients discharged from Primary Mental Health services across North Wales in March 2020. The review cross-referenced the names of discharged patients against Datix incidents, Section 136 assessments, Psychiatric Liaison assessments and Mental Health admissions.

The review identified 68 individuals who had been discharged from primary mental health services in March 2020, and had further contact with mental health services between the 23<sup>rd</sup> of March and the 2<sup>nd</sup> of June 2020. Of those 68 individuals 10 were admitted to inpatient MH services, 3 were subject to Section 136 assessment that did not result in an admission, and 2 related to Community/Duty support.

Whilst the review identified that none of the individuals came to a measurable harm during the time period reviewed, it cannot determine if any deterioration in mental health resulting in admission, S136 assessment or Psychiatric Liaison assessment was a natural development of their MH condition, or as a direct outcome of being discharged.

***Recommendation 9. To undertake an option appraisal of interim improvements to IT system support for the MHL D division, whilst awaiting the roll out of Welsh Community Care Information System (WCCIS).***

Exploring alternative solutions was paused during the Covid19 response 20/21. This work is now being reinvigorated; a WCCIS position paper (WCCIS options appraisal, March 2021) was presented by Informatics to the Digital & Information Governance Committee in September 2020 setting out the background of supplier delays, and outlining the impact on the Health Board's ability to deliver Care Closer to Home. The committee approved the proposal to develop an option appraisal to consider whether the project should seek alternative solutions which may better support the Health Board's strategic and operational objectives.

The options appraisal has been discussed within the Division and we are now engaged to assess the current capabilities of the system. Option 1 has been identified as the preferred option by Informatics, which means they will continue to work with the supplier and the National team, seeking to implement V5 of the WCCIS system at the earliest opportunity once key interfaces are available, and using a phased approach to scale-up as new functionality is released. It should be acknowledged that there remains to be a number of unresolved technical concerns with this version. The Division is currently working with Informatics colleagues to set

up a 'sandpit' environment so that some of our clinical team can test the system, and feed into the business case moving forwards.

A full review of the current WCCIS business case will be crucial to ensure that any decision meets the operational and strategic requirements of the Health Board, and remains based on a sound financial model. Contractual discussions are underway to negotiate deployment based on functional delivery milestones. It is proposed to integrate the WCCIS and CRT business cases into a new 'Digital Community Services' business case, to reflect the early requirement of technology to support mobile working in advance of WCCIS delivery and to support re-recruitment of a team to deliver the agreed product.

With regard to further consideration of an alternative interim solution; the Division and Performance colleagues have undertaken initial mapping of pathways (supporting the identified key performance indicators), and are confident that with additional functionality, the existing and supported Welsh Patient Administration System (PAS) system could present intermediate opportunities and efficiencies. This would require further scoping and would need to be considered alongside the proposed implementation of WCCIS.

**Divisional Action Plan** (a version incorporating evidence is also maintained and is available on request by members)

No.	Recommendation	Action	Action Lead	Action Due Date	Action Completion Date
1.	To reconsider the MHL Division governance structures, including how area mental health teams work together as one service, to ensure common understanding, and service delivery processes.	Governance structure aligned to Corporate Structure with a formal handover of Divisional Governance to the Associate Director of Corporate Governance and Patient Safety.  Approval and implementation of the MHL Divisional COVID19 Winter Plan outlining governance structure during COVID19	Hilary Owen Head of Governance  Carole Evanson Interim Deputy Director and COVID19 Lead	April 2021  November 2020	01/04/2021  November 2020
2.	To refresh and improve communication processes in the division to better support a two way flow of information, ideas, suggestions and decision making between the directors and the operational area mental health teams.	Implementation of the MHL Divisional Covid19 Winter Plan with clear lines of communication via Gold Command to Heads of Operations and Service Delivery to Business Support Managers and Area Safety Huddles.  Implementation of Divisional Senior Leadership Briefing Meeting  Implementation of Divisional COVID19 Briefings to entire workforce supported by Communication Team	Carole Evanson Interim Deputy Director and COVID19 Lead  Carole Evanson  Carole Evanson	November 2020  November 2020  July 2020	November 2020  November 2020  July 2020
3.	To agree and adopt common terminology for primary care and community mental health services across the MHL division, Health Board and key stakeholders.	Divisional COVID19 Clinical Pathway Plan  Pathway Development Community Pathway - Dr Malik Acute Pathway - Dr Pierce	Alberto Salmoiraghi MHL Medical Director  Amanda Lonsdale Interim Deputy Director	November 2020  30/06/2021	November 2020
		<i>As part of this work, the attached SOP will need to be refreshed in collaboration with key stakeholders.</i>			
4.	To ensure a clear definition of roles and responsibilities across primary care and community mental health services, with consideration as to the need for consistent management structures and roles across the area mental health teams.	Pathway Development  Community Pathway - Dr Malik Acute Pathway - Dr Pierce  <i>As part of this work, the attached SOP will need to be refreshed in collaboration with key stakeholders.</i>	Amanda Lonsdale Interim Deputy Director	30/06/2021	
5.	To develop engagement processes and joint working across the MHL division, ensuring a better understanding of decision-making and accountabilities	The division will be appointing a Director of Operations which will provide senior leadership across operational services and will act as a key conduit between operational services and the divisional senior leadership team.  The governance arrangements across the MHL division have been reviewed and shared with area senior leadership teams in order to ensure clear lines of communication are embedded	Amanda Lonsdale Interim Deputy Director	31/05/2021	
6.	To improve engagement and collaborative working between the MHL division and clusters, with local area mental health teams sharing their current practice and suggestions.	An engagement action plan will be developed in partnership with clusters. This work will be led via the Deputy Director MHL and the Assistant Director of Primary Care and Community.	Amanda Lonsdale Interim Deputy Director	31/05/2021	
7.	To review the Part 1 MHM model of care in North Wales, to include engagement with the three Area Divisions, clusters and other key stakeholders	Community Pathway Development - Dr Malik  Together for Mental Health Strategy	Amanda Lonsdale Interim Deputy Director  Llinos Edwards	30/06/2021	
		The division will undertake a review of the implementation of the embedded document implementing the Mental Health (Wales) Measure 2010 and produce an action plan which will be worked through key stakeholders including GP clusters.	Service Improvement Programme Manager	30/06/2021	
8.	To review all Datix entries relating to PCMH patients made between 23rd March 2020 to 3rd June 2020 as further evidence as to whether any patient harm was caused	Comprehensive Review of Datix reported to Divisional QSE December 2020	Hilary Owen Head of Governance	September 2020	September 2020
9.	To undertake an option appraisal of interim improvements to IT system support for the MHL division, whilst awaiting the roll out of Welsh Community Care Information System (WCCIS).	Options appraisal regarding alternative solutions.  Mapping of Pathways aligned to Welsh PAS  Review of the WCCIS Business Case	Keeley Twigg Head of Planning  Performance  Performance This work is on-going within Information Department	March 2021  March 2021	March 2021  March 2021

## **5. Conclusions - Aligned to Divisional Priorities**

### **Review of capacity**

The Mental Health Division is not where it was in April of 2020 capacity wise. There has been significant restoration of people in positions since September, with many returning to work and mitigating appointments to assure capacity to operate safely and soundly. This also includes restoration of the area management's structures in MHLD which is now complete. There has also been the movement of senior staff from area management to other areas management teams with the aim of reducing variation.

The report highlights that the Division's management structure was "hierarchical and complex". The Division accepts this and in its regrouping has focussed on a simple restored triumvirate, with appropriate and timely support from other functions to enable this. This is now in place since October 2020. The Division will now consider its formal management structures, and fitness for meeting the priorities as we plan for the future.

### **Stronger and more aligned governance and management**

Considerable work has been completed to align the governance structure within the division to more closely reflect and interact with the BCUHB structure. The Division will consider this when they meet to consider how we have more aligned internal management to reduce variation and the risk of "solo actions" as it considers how its areas functions and specialities, as well as how its wider professional groups are led and represented in decision making .

The Divisions "gold command structure" has been enabled and its Silver structure has been enabled 7/7 since December. A Standard Operating Procedure (SOP) for this was drafted and circulated for consultation throughout the Christmas period. This has been in place since January 2021 and reflects the learning from the first phase.

The Division's Clinical Advisory Group (and corporate CAG that oversees) remains the centre of clinical advice and recommendation within the division. All senior managers and area Heads of Operations are invited and are now both regular attenders and contributors to this meeting. The meeting is well attended and the Division feels more robust and inclusive in its decision-making. We will continue to review this and have invited wider professional representation as well as contributions and sharing from partners e.g. Local Authorities. This group recommends actions to the Senior Leadership Team (SLT) who make decisions informed by them.

The Division will ensure that compliance with the governance structure of the organisation is addressed as it further develops its clinical pathway approaches, ensuring that model fidelity and pathway coherency as agreed in CAG are assured to reduce variation and reduce risk of individuals being able to act outside of agreed approaches.

The Division recognises that Part 1 of the Mental Health Measure (Wales) is a statutory instrument and such services to achieve compliance cannot be “stopped”

The MHL D Structure is too complex and too hierarchical with potential for operational and especially area disconnectedness. The division will aim to further simplify its management structure as it continues implementing the 4 priorities of the division.

### **Engagement with users and stakeholders**

The Division is growing its engagement plan now it has a Deputy Director (Interim) in post, supporting the Director for MHL D specifically with this domain, and we are already striving to make significant cultural changes.

The Division recognises that our alliances with the wider health and social care economy as well as with those we support (our communities) have to inform our structural considerations, to make this sustainable.

The Division has recommenced its Patient and Carer experience subgroup from October 2020 (Paused again due to command structure January to March 2021, now recommenced).

The Division needs this work to progress and be seen as an equal and reliable partner that participates openly with allies in these difficult times of competing pressures and the pandemic response.

### **Delivery of safe and effective care in partnership**

The Division should not have acted unilaterally and without due consideration of the impact upon patients or our partners. The fact we did, indicates a cultural problem we have to address - through our management structure and our operational delivery of services within the 3 geographical areas of our mental health services, and through our longer term workforce development Plan

We have not yet developed fully robust and sustainable relationships with our partners within BCUHB, nor our wider communities. This will be at the forefront of our Divisional priorities in 2021/22 as we have restored capacity and aligned governance and management through late 2020/21.

The Division recognises that in recent history it has appeared inward focussed, i.e. within MHL D division. It is reviewing its organisational structure (and culture) to ensure operational delivery plans are enacted, and that the leadership team have the capacity and capability, as well as the intent to develop more integrated working across the whole health board – in working together for mental health.

The Division will establish bi-annual meetings with the 3 Triumvirates from the Area teams in BCUHB to start the conversation of better and closer partnership working. Leading from that, we can work through the respective Integrated Services Boards. We have begun engaging in this style with Child and Adolescent Mental Health Services (CAMHS) and so far it has been mutually beneficial, informative and allows triumvirates to share risks and to plan effectively.



<b>5.</b>	<b>Recommendations to the QSE Committee</b>
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The Committee is asked to note:-

- That the division fully accepts both the findings and recommendations of the report
- That the division has considered and stated its learning from the report
- That the division has stated its actions to prevent recurrence both tactically and strategically as it plans its next steps



<b>Cyfarfod a dyddiad: Meeting and date:</b>	Quality, Safety & Experience Committee 4 <sup>th</sup> May 2021					
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public					
<b>Teitl yr Adroddiad Report Title:</b>	Mental Health and Learning Disabilities Exception Report					
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Teresa Owen, Executive Director for Public Health, (Executive Lead Mental Health and Learning Disabilities)					
<b>Awdur yr Adroddiad Report Author:</b>	Mike Smith, Interim Director of Nursing Mental Health and Learning Disabilities Iain Wilkie, Interim Director for Mental Health and Learning Disabilities					
<b>Craffu blaenorol: Prior Scrutiny:</b>	Divisional Directors Mental Health and Learning Disabilities					
<b>Atodiadau Appendices:</b>	None					
<b>Argymhelliad / Recommendation:</b>						
The Committee is asked to note the update from the Mental Health & Learning Disabilities Division.						
Please tick as appropriate						
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>	x	<b>Er gwybodaeth For Information</b>
<b>Y/N to indicate whether the Equality/SED duty is applicable</b>						<b>N</b>
<b>Sefyllfa / Situation:</b>						
<p>This is an exception report from the Mental Health and Learning Disabilities Division (MHLD) to highlight to Quality Safety and Experience (QSE) key issues of significance and the management actions in place. This regular QSE report is structured around the four divisional priorities of :-</p> <ul style="list-style-type: none"> <li>• Stronger and Aligned Management and Governance</li> <li>• Review of Capacity and Capability</li> <li>• Delivery of Safe and Effective Services in Partnership</li> <li>• Engagement with Staff, Users and Stakeholders</li> </ul>						
<b>Cefndir / Background:</b>						
<p>This report forms part of regular updates to QSE Committee on the Divisional MHLD QSE actions and performance.</p> <p>The report is written around the 4 strategic priorities, alongside the key risks in each area with the corresponding actions to mitigate or minimise risk. At the end of the report, the Divisional leadership team have summarized the position.</p> <p>Going forward, the Division will be taking the Socio-economic Duty and Equality Impact assessment</p>						

into account if strategy changes are considered.

**Strategy Implications**

This report outlines the implementation of the next phase plan and compliance with the mental health measure (MHM).

**Options considered**

None appropriate

**Financial Implications**

A financial assessment has not been included within this exception report.

**Risk Analysis**

Risks are highlighted in each area reported, as are corresponding mitigating actions where appropriate.

**Legal and Compliance**

This report provides data on compliance with the MHM.

**Impact Assessment**

There are no proposed service changes within this report and all policies follow due process for EQIA.

## **Mental Health and Learning Disability Services**

### **1.0 Purpose of report**

This report provides an update on QSE actions and performance aligned to the four MHLD priority areas, highlighting the measures in place, key risks in each area, and corresponding mitigating actions. It also provides the Committee members with an exception report on the quality and performance assurance metrics within Mental Health and Learning Disability Services.

### **2.0 Mental Health and Learning Disabilities Priorities**

1. Stronger and Aligned Management and Governance
2. Review of Capacity and Capability
3. Delivery of Safe and Effective Services in Partnership
4. Engagement with Staff, Users and Stakeholders

#### **2.1 Stronger and Aligned Management and Governance**

##### **2.1.1 Divisional Directors and Senior Leadership Arrangements**

###### Measures in place

The appointment of an Interim Divisional Director of Operations (to restore robustness and capacity) to the Senior Leadership team is in process, with interviews planned in April 2021. The interview panel includes local authority partners given the key relationship aligned to the strategic priorities of the Division.

The Division is reviewing the Terms of Reference and workplan of its Patient & Carer Experience (PCE) sub group to more closely align to BCUHB PCE governance function.

The key elements of the Targeted Intervention Improvement Framework (TIIF) have been built upon by the Division in its first iteration of its 'draft' Maturity Matrix to include the 4 strategic priorities. (This is recommended practice in a TIIF to adapt and include strategic priorities for quality improvement into the key elements in the framework).

###### Identified Risks

- The Division's senior leadership team may not have the required capacity or sustainability to deliver the strategic priorities.
- The Division may not be working optimally as part of a whole system approach to Mental Health service delivery.

###### Improvement actions

Monthly joint meetings with the Children & Adult Mental Health Services (CAMHS) leadership team has been established to discuss joint working and issues. These meetings will also discuss Targeted Intervention (TI) coordination - as both Divisions

are subject to Targeted Intervention (TI) and transition is a key collaboration area for both parties. Other focus areas are 24hr access and place of safety.

The MHLD Division intend to have a similar approach to joint meetings with BCUHB Area teams (as described in our LPMHSS - Local Primary Mental Health Support Services discharges paper).

## 2.1.2 Outcome of Internal Audit MHLD/Governance

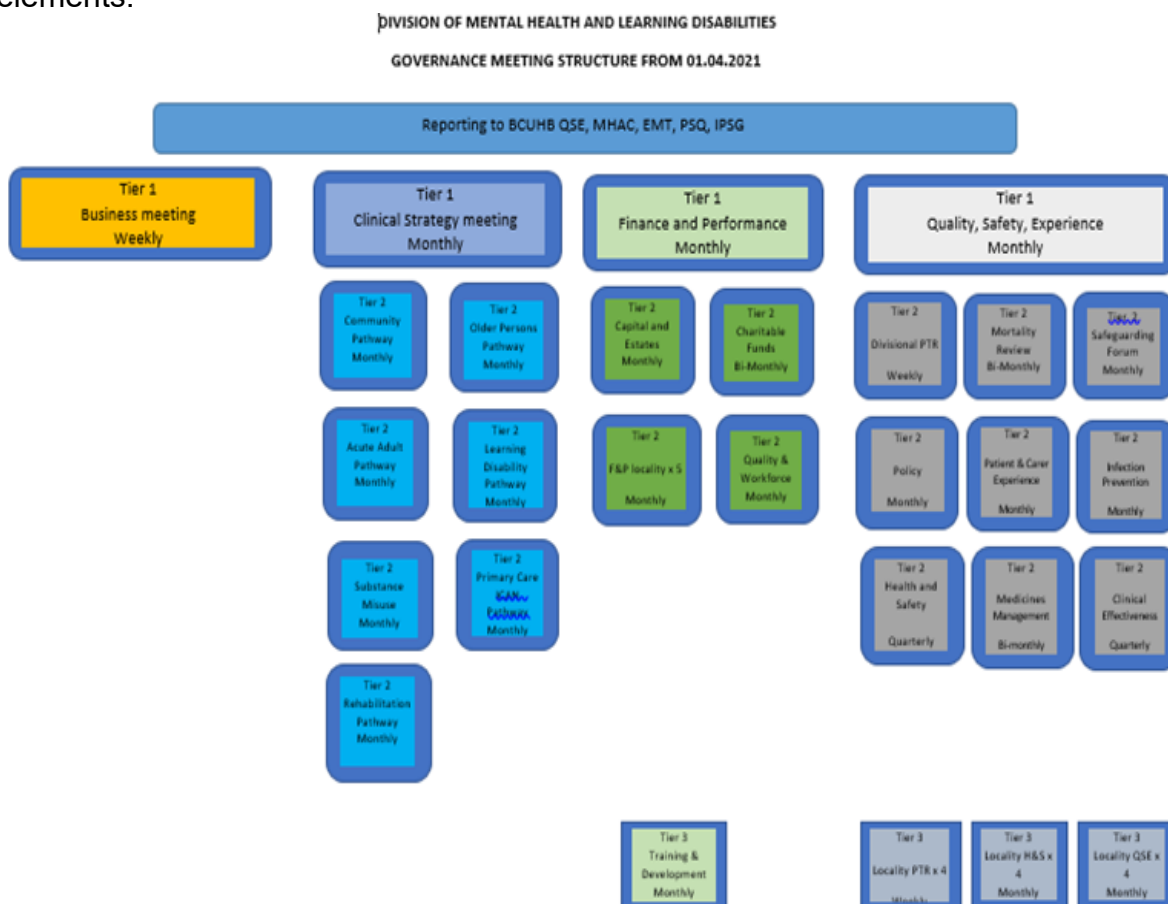
The Division previously reported to QSE Committee the draft findings of the Internal Audit Report into its Governance Arrangements for 2020/21. The report identified the level of assurance as “limited assurance”. The final report has been received by the Division and the formal management response submitted. The key actions related to the 3 recommendations are reported below.

### Recommendation 1

The Lead Executive Director for Mental Health reviews the governance and management structure and whether it remains fit for purpose.

### Management Response & Improvement Action

The Division has reviewed its Governance and Accountability Framework. It is a key internal governance document for the Division and its purpose is to maximise transparency, efficiency and accountability regarding Divisional arrangements. The framework sets clear expectations on standards, roles, accountabilities and responsibilities across the Division. The Divisional Senior Leadership Team meet weekly. The membership and terms of reference for this team have been developed to be aligned to the business of the day. The diagram below summarises the key elements.



### Recommendation 2

The Health Board revisits the “Strategy” as a matter of urgency, to ensure it remains relevant in delivering and supporting Mental Health services in North Wales.

#### Management Response and Improvement Actions

The principles of “*Together for Mental Health*” and “*A Healthier Wales*” remain the strategic focus for delivery of Mental Health and Learning Disability services in North Wales. In line with the recommendation, MHLDD will undertake a review and refocus to ensure services can respond appropriately to demand. The MHLDD Division will ensure there is a robust process established to ensure monitoring, and achievement of key milestones.

### Recommendation 3

The Health Board consider whether all Psychological Therapy Services remain appropriately supported within the Division or become hosted/stand-alone services.

#### Management Response and Improvement Actions

The MHLDD Division acknowledge there is a need to re-engage with the Psychology workforce. A key priority will be to ensure there is a Head of Psychology in post as part of the Senior Leadership Team to lead engagement with Psychology colleagues and determine clear proposals for the delivery of psychological therapies.

## **2.1.3 Risk Management Strategy**

### Measures in place

Significant work has been undertaken recently to streamline the Divisional risk register and ensure that risks are current, relevant, and compliant with the risk management strategy. The Divisional risk register currently comprises of 8 risks that are being regularly reviewed.

Risks are reviewed, scrutinised, discussed and approved at Locality QSE, Locality ‘Putting Things Right’ (PTR) meetings, Divisional Directors QSE, Divisional PTR, Medicines Management sub-group, Safeguarding Forum, Health and Safety locality groups.

The Head of Governance and Interim Director of Nursing meet on a monthly basis to fully scrutinise and update the risk register. These regular reviews ensure that historic risks that are being mitigated and managed operationally are closed, with the option to reopen should the situation change.

A risk register report is received at the Divisional QSE meeting ensuring that Divisional Directors are sighted on Divisional Risks.

## Identified Risks

The identified key risks are shown below:

ID	Ref	Handler	Title	Opened	Risk Type	Risk level (current)	Risk level (Target)	Risk Rating (current)	Date of Last Review/Update	Date of Next Review/Update
3085	MHLD(E)78	Head of Operations East	There is a risk that governance processes are not being fully adhered to	19/02/2020	Tier 3 - Divisional	Low	Low	2	30/03/2021	30/04/2021
3460	MHLD(R) 80	Head of Operations RSS/SCC	There is an environmental risk in relation to Tan y Coed where the building is deemed uninhabitable	12/06/2020	Tier 3 - Divisional	Moderate	Low	6	13/04/2021	31/05/2021
3768	MHLD 90	Director of Nursing MHLD	There is a risk in relation to sustainability of the Division and its credibility	05/01/2021	Tier 2 - Directorate	High	Low	9	13/04/2021	30/04/2021
3769	MHLD 91	Director of Nursing MHLD	There is a risk that MHLD governance is not fully integrated with BCUHB governance processes	05/01/2021	Tier 3 - Divisional	Moderate	Low	4	13/04/2021	30/04/2021
3771	MHLD 93	Deputy Director MHLD	There is a risk that the Division has poor strategic partnerships and relationships in the wider health and care economy	05/01/2021	Tier 2 - Directorate	High	Low	9	10/03/2021	13/04/2021
3770	MHLD 92	Director of Nursing MHLD	There is a risk that the Division is not sufficiently connected to its users and stakeholders including its workforce	05/01/2021	Tier 2 - Directorate	High	Low	9	13/04/2021	30/04/2021
3773	MHLD 94	Head of Governance	There is a risk in regard to the number of legacy workforce issues that are unresolved	07/01/2021	Tier 2 - Directorate	High	Moderate	9	13/04/2021	30/04/2021
3788	MHLD(C)95	Head of Operations Central	There is a risk to the patients in Tegid ward due to temporary change of function	29/01/2021	Tier 2 - Directorate	High	Moderate	9	10/03/2021	31/03/2021

## Improvement Actions

The Division continued to work to the Q3/Q4 Winter Plan during the last period, with agreed profiles against key government targets. Recent efforts have focused on shaping MHLD section for the annual plan for 21/22, and the longer term plan will be developed with full engagement and collaboration with our workforce and wider partnerships.

Welsh Government published their Together for Mental Health Delivery Plan in January this year, which outlines their strategy for improving mental health in Wales from 2019 to 2022. The plan contains actions and milestones for services, Health Boards and a range of sectors to work together with the Welsh Government to deliver. The plan looks at four overarching priorities including: reducing health inequalities; promoting equity of access and supporting the Welsh language; strengthening co-production and supporting carers; workforce; research, data and outcomes.

The Q3/4 (20/21) plan update showed good progress on delivery. Some delay has been identified - for example, the revised dates to progress the Ablett Outline Business Case (OBC).

The Division's priority focus to date has been on service critical issues as reported. However as the Division has restored capacity in management roles, it is apparent that there are a number of longer term risks around engagement and partnership to be addressed. More emphasis is to be placed on building capacity and delivery in this priority area.

## **2.2 Review of Capacity and Capability**

### **2.2.1 COVID-19 Divisional Plan**

Following the full review of the MHL Divisional COVID19 plan aligned to the first phase of the COVID19 Pandemic, the MHL COVID19 Winter plan was developed, approved and operationalised during the second surge of the pandemic.

#### Measures in place

During this period of increased pressures and demand, additional Divisional measures have been put in place to ensure a coordinated approach for decision-making, escalation and effective management.

The MHL Division established a hierarchical framework for the command and control of its operations to manage its response to the pandemic. A Divisional Operational and Tactical Command structure was stepped up. This included developing:

- MHL Command Structure SOP (Standard Operating Procedure)
- MHL Tactical Control Centre SOP
- MHL Command Inbox protocol
- MHL Handover document
- MHL Covid19 Gold Command meetings
- MHL Covid19 Senior Leadership meetings

During the second surge of the Covid19 Pandemic, the MHL Division reflected on the lessons learnt from the first wave to ensure appropriate steps were taken.

The MHL COVID19 Clinical Pathway, approved by both MHL Clinical Advisory Group and Corporate Clinical Advisory Group in the first wave, continues with inpatient cohorting. Due to the experience of phase one, the data and a re-examination of the estates, area cohorting continued, with the exception of people with Dementia.

The MHL area Situational reports (Sitrep) continue to be completed 7 days a week. A Sitrep Governance Pathway has been developed to ensure monitoring and review/oversight of the Divisional position, inform decision making and timely daily submission to BCUHB Tactical control. The Sitrep summary position is reviewed during MHL COVID19 Gold Command meetings and MHL COVID19 Divisional Senior Leadership meetings and any issues where the risks cannot not be mitigated locally are escalated appropriately.

A MHL Divisional Personal Protective Equipment (PPE) Task and Finish Group established in the first wave, continues to meet on a monthly basis, reporting into MHL COVID19 Gold Command meeting as well as the MHL COVID19 Divisional



Senior Leadership meeting. Guidance was included in the MHL D Winter Plan and regular PPE updates were included in the MHL D Staff Briefings.

COVID19 related training is in place with compliance monitored and reviewed through Workforce Work stream.

The MHL D Divisional Workforce meeting has been replaced by the MHL D COVID19 Divisional Senior Leadership team meeting to review workforce planning, and any workforce related activity reports.

The 'Attend Anywhere' has been operationalised across several areas of the MHL D Division to provide a virtual consultation platform.

Joint Partnership Group meetings with Staff Side continue monthly to enhance communication, engagement and collaborative working with partners. The Terms of Reference (TOR) has been developed, and the meeting Chair rotates between the MHL D Lead and the Staff Side representative to enable joint partnership working.

The MHL D Divisional Silver on call continues to operate to support bronze on call with increased pressures, 7 day Sitrep reporting and to provide timely additional advice and support with any service delivery issues.

#### Identified risks

- There could be insufficient staffing resources to meet demand.
- Flexible and responsive communication may be impacted during Covid19 pandemic.
- Upskilling of staff identified for redeployment may not be sufficient during the pandemic.
- Information technology and equipment to support operations may not be sufficient due to demand exceeding supply of laptops and VPN's.

#### Improvement actions

MHL D COVID-19 Gold Command meetings and MHL D COVID19 Senior Leadership meetings continue to discuss and review the Divisional workforce planning, and any workforce related activity. This includes a focus on recruitment to vacant posts, review of the MHL D Divisional absence reports, local redeployment, staff support and the monitoring and review of social distancing action plans.

MHL D Wellness, Work and Us Strategy (Year 1) priorities have been agreed, and are monitored and reviewed through the Command structure meetings.

In order to strengthen the communication and engagement of the MHL D Division a 'Communication and Engagement' plan was developed. This included regular staff briefings circulated across the Division with key messages and Joint Partnership Group meetings with Staff Side representatives to ensure enhanced collaborative working and proactive communication. The implementation of the MHL D Command Centre inbox protocol has ensured timely responses. Increased partnership working has strengthened communication and engagement with both external and internal stakeholders. The Divisional Directors and Gold Command have (and continue to) focus on increasing visibility.

Additional training needs aligned to Covid19 have been monitored and reviewed by the Workforce Workstream group, which reports into the MHLG Gold Command meetings and Divisional Senior Leadership meetings. A MHLG Development and Training Group is being established to provide additional focus and oversight.

A Covid19 funding application process has been progressed for all equipment requirements, with a priority matrix implemented to ensure when equipment becomes available it is allocated accordingly.

The Division has increased its engagement with the Information Technology (IT) services, to ensure efficient and effective delivery of laptops across the MHLG Division, aligned to the local prioritisation.

### **2.2.2 MHLG COVID19 Inpatient Vaccination Programme**

The MHLG Division has responded proactively to the requirement to vaccinate inpatients, following the Joint Committee of Vaccination Immunisation advice from January 2021 to current date. At the time of report, 76% of all MHLG inpatients had received the first dose of the vaccine and 45%, their first & second dose [06.04.21]. Since January 2021 the division has vaccinated inpatients with 204 1<sup>st</sup> doses and 117 2<sup>nd</sup> doses.

The Division has created a Standing Operating Procedure that governs how each part of the Division is responsible for ensuring identification of new patients for vaccination and governance around training of immunisers. The Division will be taking forward plans to identify how staff can support with the immunisation of hard to reach people with MHLG who live in the community. This initiative is being undertaken in conjunction with primary care partners.

#### Identified Risk

- The MHLG Division has had a single DATIX generated related to the inpatient vaccination programme and this was a Welsh Immunisation System (WIS) data error (patient assumed to be vaccinated but not vaccinated). This incident was promptly investigated and a learning bulletin produced and disseminated across the Division.

#### Improvement actions

The MHLG Division will continue to ensure its oversight of the progress on inpatient vaccination, to ensure public protection measures are effective. The reporting of inpatient vaccination will form part of business as usual from May 2021.

### **2.2.3 Recruitment & Retention of Staff**

MHLG Gold Command meetings and Divisional Senior Leadership meetings review any staffing pressures across the Division. The meetings review the weekly Staff Absence report, BAME (Black Asian & Minority Ethnic) Risk Assessment Report, Vacancy and Recruitment report and staffing position for each clinical pathway and any items for escalation.

### Measures in place

The Wellness, Work and Us Strategy was launched in October 2020, to ensure staff are supported. The strategy was approved by the MHL D Divisional Directors within the Divisional Business meeting September 2020. The Wellness, Work and Us workstream group report on the metrics established, and monitoring and review arrangements are in place to understand performance. This provides information regarding our staff wellbeing. A quarterly update report is discussed in Divisional Gold Command meetings and Divisional Senior Leadership meetings.

In order to understand better staff anxieties and ensure appropriate support – a staff survey was undertaken. Following a thematic analysis, actions have included:

- Ensuring staff space for quiet time
- A staff resource centre
- Wellness sessions
- Implementation of a coaching programme
- A review of staff induction packs
- Appointment of a counsellor to provide proactive support

The Division has also commenced its discussions with Workforce & OD colleagues to support key themes/progress actions.

## **2.3 Delivery of Safe and Effective Services in Partnership**

### **2.3.1 Heddfan Unit Improvement**

The development of the Heddfan Quality Improvement Plan (HQIP) has been previously reported to the QSE Committee. The HQIP pulled together actions from the initial Healthcare Inspectorate Wales (HIW) concerns in June 2020, and subsequent actions following their visit and actions from learning from other events. In late 2020, the Division reported the following key risks and recommendations:

#### Key Risks

- Recruitment and Retention of Qualified Nurses may be inadequate to deliver an effective service .
- There could be an over reliance on the use of agency and bank staff.
- On-going training for clinical staff beyond statutory and mandatory training may be inadequate

#### Recommendations

- Interim arrangements for Head of Nursing and Matron posts moved to a substantive appointment.
- The SLT adopt the audit cycle framework created by the Interim Improvement Director as part of the embedding process to change.
- HQIP meetings are replaced by a fortnightly ward manager meeting led by the Head of Nursing to hold to account the ward managers as part of delivering the audit framework.
- Group supervision is conducted monthly with Ward Managers with the Head of Nursing.

- Adverts for qualified nurses are ongoing, however these remain difficult to fill especially for Band 5 Staff members. It is anticipated that in April 2021, the Heddfan Unit will welcome up to 16 newly qualified nurses, who will assist in filling the vacancies. The Associate Director of Nursing will be working with the teams to ensure the appropriate support and allocation is planned as part of retaining the new recruits

### Measures in place

A newly established Senior Leadership team (SLT) is in place in Heddfan, which includes the Interim Head of Operations (HOP) and a now substantive recruitment to Head of Nursing (HON), as well as two inpatient service managers covering both adults and older people (both on an interim basis). The permanent recruitment of the adult inpatient service manager has now commenced. The business case for a permanent Older Person's Mental Health (OPMH) inpatient service manager is being progressed for SLT consideration.

Core meetings have been embedded over the past 3 months and provide the assurance and governance required for the operational running of services and to improve quality and safety for patient care. This has included the implementation of a monthly workforce meeting, finance meeting and weekly operational accountability meetings.

Systems and processes have been reviewed and implemented to ensure all staff are aware of roles and responsibilities and to support the workforce process when addressing issues in relation to staff sickness and performance.

There has been a focus across the East area team in relation to Key Performance Indicators (KPI's). This is reviewed by service managers.

The East area has reopened the Psychiatric Intensive Care Unit (PICU) ward to a 3 bed unit (to ensure safe and robust staffing) with staff returning to substantive roles and older persons wards have returned to both admission and treatment for the area. This has addressed concerns raised by staff who have returned to their substantive roles. During the latter part of April 2021, the PICU ward will open up to a 6 bedded ward as increased staffing becomes available.

Ward managers will continue to focus on ensuring staff receive the right support and supervision to fulfil their roles and responsibilities. Themes have included implementing formal and informal supervision, meaningful personal development reviews and allocated time to fulfil mandatory and additional training in order to meet the needs of patients as well as personal development.

A final 'service of concern' meeting was held on 9<sup>th</sup> March 2021 to review an outstanding action in relation to receiving clarification that robust recruitment policy and procedures are in place and that the Disclosure and Barring Service (DBS) process is monitored and managed. Assurance was provided that the DBS process had been reviewed, and the MHL Division can confirm that an up to date risk assessment is in situ for any staff who may have a conviction prior to appointment or during service.

The service of concern meeting was satisfied with the update and assurances as well as the progression to date; which included an update from safeguarding highlighting progress made, and systems were now in place, positive feedback from the 6 weekly meetings with safeguarding colleagues and a significant improvement with the numbers and quality of reports. Healthcare Inspectorate Wales (HIW) also concluded they had received a recent update on an inspection of the improvement plan with positive actions. The meeting concluded that all outstanding actions had been addressed and the 'Service of Concern' was now closed.

### Identified Risks

- Initially the HQIP identified 16 area for improvement. 14 of these actions have been achieved. The following two actions are outstanding and remain amber in status:
- 1) Recruitment into the Advanced Nurse Practitioner (ANP) role commenced as a permanent post with interviews scheduled for early March 2021. Unfortunately, the recruitment was unsuccessful following two rounds of advertising. A meeting has now been set up with the area team to agree a plan of rotational staff who work within the general nursing team and will provide weekly physical health clinic's into the wards providing an independent view and linking closely with the Multidisciplinary Team (MDT). This approach will provide more robust cover arrangements and continuity and also supports the Division's approach for better partnership working across the Health Board.
  - 2) The erection of a sun canopy in the internal courtyard is currently under review by the Estates team. The initial deadline for completion was 31<sup>st</sup> March 2021. The timescale for completion has been reviewed and amended with a new deadline of 31<sup>st</sup> May 2021, to reflect recent challenges in the sourcing and erection of the canopy.

All actions previously completed will remain under review and are incorporated into East area objectives to support ongoing service improvement. This will include the audit cycle framework, which is monitored via the HON through QSE.

### Further Improvement Actions

In response to concerns regarding staffing levels (raised by staff), the MHLA Area SLT have reviewed and updated the staffing template in collaboration with ward managers to reflect the need and agreed the staffing template moving forward. A clear process has been implemented for oversight of an e-roster and shift lockdown, with data reported monthly to the SLT for assurance and oversight. The bank office is supporting the recruitment of bank staff on temporary contracts to meet the current staffing challenges and to reduce the use of agency staff. This will support consistency and continuity for both patients and staff.

Concerns raised by staff specifically around communication between nursing staff and the wider Senior Leadership team have been addressed with all members of the SLT ensuring visibility across the Heddfan unit. Inpatient Service managers are spending a significant amount of time across the teams and wards. Regular updates are being shared with all staff across the area to share developments, and

encourage staff to engage with discussions and share ideas. A nurses' forum has also been implemented. Feedback from the nursing forum has been positive from all staff.

The ongoing recruitment and retention of staff remains a challenge however clear systems and processes have been implemented to ensure timely recruitment to vacancies. Vacancies are discussed weekly at MHLA Area SLT for oversight.

### **2.3.2 Local Primary Mental Health Support Services (LPMHSS) Mental Health Measure (MHM)**

MHM performance across the Division is on target with the exception of Denbighshire Part 1a and 1b. Within Denbighshire there are patients awaiting outcomes to be recorded within data systems and this will help improve the position. The Division intends to utilise resource outside of the team for this to ensure that the team can continue its focus on patient care. Recruitment to the MHM Lead post will offer support in relation to developing trajectories for compliance.

#### Measures in place

Performance is subject to robust area management and is discussed weekly by the Heads of Operations in each area, with remedial action plans put in place where necessary - for example the West area have introduced further extra assessment clinics for 3 weeks beginning 17<sup>th</sup> April to avoid a drop in performance which is predicted by demand and capacity forecasting. MHM performance is also addressed in monthly supervision with Service, County and Team managers. The East area is assessing the need to introduce additional assessment clinics to ensure timely management of referrals and avoid further breaches.

#### Identified risks

- Staffing establishments may not receive timely review to reflect a potential increase in demand due to the expected impact of the Pandemic on mental wellbeing levels across communities.

#### Improvement actions

Some staffing risks remain where teams have high numbers of staff members on sick leave/isolating due to the current pandemic. (The East area has had the highest incidents of Covid19).

Recruitment to vacant posts is ongoing with the support from the Divisional Directors.

Action has been taken in Ynys Mon to trial online interventions groups. The aim is to reduce the wait for interventions during the pandemic. The focus is on a cohort of patients awaiting interventions under the measure, for whom the intervention would satisfy the identified clinical need.

## Part 2 MHM

Gwynedd has seen a recent dip in performance with regard to care and treatment plan (CTP) compliance. All care coordinators are alerted on a weekly basis to any CTP which is approaching non-compliance and CTPs are discussed in team and individual supervision. Staff absence has impacted negatively upon performance but this is expected to resolve during the next month. A data cleanse activity is ongoing.

A reduction in compliance across Part 2 in Conwy is due to vacancies and long-term sickness, which has resulted in a waiting list for allocation. Agency support has been agreed for 12 weeks with immediate effect.

Flintshire and Wrexham are compliant.

Scrutiny is required to ensure ongoing compliance is proactively managed. Challenges have been identified in relation to large caseloads for consultants and a plan has been implemented to address this. Recruitment of a Service Manager and Clinical Operational manager is imminent and will support the teams to address issues proactively.

Overall, there are ongoing plans to review the capacity and demand within the teams and carry out caseload reviews.

### **2.3.3 Healthcare Inspectorate Wales (HIW)**

#### Coed Celyn HIW

HIW undertook a remote quality check of Coed Celyn Rehabilitation Unit on the 17<sup>th</sup> March 2021. The review focused on the environment, infection prevention and control measures, and governance arrangements. Draft feedback from HIW indicates a positive review of services noting that discussion with the ward manager indicated they were well supported by their immediate line manager and by the wider organisations senior management team. HIW identified one improvement action for the Unit relating to the undertaking of an infection prevention and control audit of the unit. This audit is scheduled for the 15<sup>th</sup> April 2021.

#### Hergest Unit HIW

HIW undertook a remote quality check of the Hergest Unit on the 30<sup>th</sup> March 2021. The Division has not yet received the HIW draft findings report or draft action plan and further updates will be submitted to QSE Committee when received.

#### Identified risks

- There are currently 14 open HIW actions within the Division for Cemlyn Ward, Ty Derbyn, Ty Llewelyn, Heddfan Unit and Carreg Fawr. The actions are in process of completion but there are known risks with delays in completion.

#### Improvement actions

Progress on the open HIW actions is reviewed at local QSE meetings across the Division with local senior leaders responsible for ensuring traction. In terms of

Divisional oversight, updates on progress are received at the Divisional Directors QSE Group where high-level support and action can be identified if required.

## **2.4 Engagement with Staff, Users and Stakeholders**

### **2.4.1 Patient and Carer Experience Subgroup and the Together for Mental Health Strategy and Operational Plan**

#### Measure in place - Together for Mental Health Partnership Board (T4MHPB)

The Together for Mental Health Partnership Board, which is the multi-agency strategic group overseeing the delivery of the North Wales Together for Mental Health Strategy, has been re-established. This Partnership Board is in the process of reviewing its TORs and planning a refresh of the Together for Mental Health Strategy with partners. This process will be supported by evidence from the outcome of the North Wales population needs assessment and provides the opportunity for the Partnership Board to influence national policy.

#### Identified Risks

There is a risk that T4MHPBPB will be acting based on dated information, and we must ensure that the impact of pandemic on the health needs of the population is considered.

#### Improvement Actions

Work is underway with Public Health colleagues to review existing population data and the development of framework to review the current Together for Mental Health Strategy.

#### Measure in place - North Wales Community Health Council (NWCHC)

Members of the senior leadership team, via TEAMS, have attended the North Wales Community Health Council (NWCHC) Annual General Meeting, and presented on the Divisional priorities. The MHLDT SLT have also met local committees and their members across North Wales to make local introductions and to ensure that the senior leadership team have the opportunity to hear and learn about local issues raised.

North Wales CHC held a number of Safe Space events between November 2020-February 2021 to seek the views of people on their experiences of MHLDT Services. The CHC held 9 themed events with over 100 total participants and have produced a draft report for the division. The Division has expressed its thanks to North Wales CHC for facilitating the Safe Space sessions, and to all the individuals who have shared their experiences to date.

#### Key Risks

- Partnership working and engagement with wider sector partners may be compromised adversely resulting in negative views of the MHLDT division amongst partners.



- The MHL Division may not address the concerns of NWCHC members or constituents leading to a lost opportunity to learn and adapt.

#### Improvement Actions

The Division has discussed with the NWCHC, running a number of feedback events where the SLT (including CAMHS) can meet with participants to thank them and address issues in the draft report directly. The Division also intend to feedback to participants and to the NWCHC, how it will use the intelligence from these events to learn and to inform the strategic direction of the Division where necessary, or influence the workforce plan where appropriate.

NWCHC officers have been invited to meet directly with the Division's Senior Leadership and Operational Management team in April 2020 to improve routine engagement, and to directly establish links with the Division's management structure. This is the first such formal invitation, as the NWCHC have not previously been invited.

#### Measure in Place - Child and Adolescent Mental Health (CAMHS)

Closer working arrangements have been established between the MHL Division and CAMHS services. (See section 2.1.1).

#### Identified Risks

- There are multiple reporting requirements across CAMHs and MHL Division, which could lead to duplication of effort

#### Improvement Actions

To agree joint reporting arrangements.

#### Measure in place - Patient and Carer Engagement Group

The Divisional Patient and Carer Engagement Group has been re-introduced which will act as a mechanism for gaining insight and feedback on consultations and engagement to make mental health services more relevant to service users and carers' needs. A work programme for the forthcoming 12 months is being developed and at the next meeting of this group, the Division will undertake a stocktake of what has worked well to date via the current group and what areas of engagement need targeted focus.

#### Identified Risks

- The group may be unrepresentative of all groups/agencies that engage with patients and carers.

#### Improvement Actions

To review the terms of reference to ensure representation is appropriate.

#### Measure in place - Engagement with Advocacy Groups

Engagement is continuing with Unllais who are commissioned to provide Patient Advocacy Services, Independent Mental Capacity Advocates (IMCA) and Independent Mental Health Advocacy (IMHA). Quarterly meetings have been set up

to ensure regular and constructive feedback on key themes resulting from this area of support.

#### Identified Risks

- Current IMCA contract arrangements end on 30<sup>th</sup> June 2021, and will require tender process to secure onward service.

#### Improvement Actions

Meeting to be arranged with relevant service leads to establish revised service specification with preparation to go out to tender to ensure continuation of service post 30<sup>th</sup> June 2021.

#### Measure in place - Area Integrated Service Boards

Opportunities to work closely with Area Teams and Local Authorities have been established with regular attendance at Area Integrated Service Boards by the Deputy Director (Interim) and similarly at the North Wales Leadership Group. These meetings provide the opportunity for wider discussions on how MHLDD can work closer with partners and move toward improved whole person care. Using the operational plan, the Division has identified the opportunity to develop a joint commissioning funding pot with Area Integrated Service Boards.

#### Identified Risks

- The Division could lack senior capacity to attend relevant meetings with partners.

#### Improvement Actions

The Interim Deputy Director is identified as the key individual to attend meetings with alternative arrangements agreed for attendance at meetings during periods of annual leave.

### **3.0 Analysis**

The Division continues to align its work to focus around the 4 priorities headlined in this report, toward the strategic aim of the “safe integration and improvement of Mental Health services”. The SLT of the MHLDD division positively regard the priorities as appropriate and current for the direction of its work going forward.

As work is completed to restore capacity and to strengthen and align governance to BCUHB process and structures, the SLT is focussing more upon its partnership working for the delivery of safe and effective services, and our engagement with stakeholders which we report in more detail, as requested, in this report.

#### **Stronger and Aligned Management and Governance**

The division has fully aligned the work of and transferred the reporting lines of its governance team to BCUHB corporate governance team. We have an active dialogue and relationship with the Associate Director of Governance and their organisational leads to review this ongoing work and it works well for the SLT of the MHLDD Division. The Division had historically developed some exemplary work in the

coproduction of services in partnership with service users and 3<sup>rd</sup> sector partners which we intend to continue, however we will ensure that the PCE sub-group of the Division now aligns more closely to the PCE structure of the Health Board.

### **Review of capacity and capability**

Work continues, with the restored capacity, to implement the priorities of the Division, with roles being appointed substantively or through long-term interim arrangements. The SLT will increase its focus on culture.

### **Delivery of safe and effective services in partnership & Engagement with staff service users and stakeholders**

As requested at the last QSE meeting this report has focused more on the work being undertaken. Management actions and measures are in place to develop the partnership working of the Division across the wider health and social care economy, and to engage with our stakeholders of our services.

We reflect on the legacy issues with partners and stakeholders who have reported experiences of feeling less engaged than they would want to be, or listened to by the MHL D Division historically. We are engaged in restoring and remedying these issues. We would like to acknowledge and thank our partners and stakeholders for ongoing support as we address this element



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	Quality, Safety and Experience Committee 4 <sup>th</sup> May 2021						
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public						
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	Quality Governance Review – Ysbyty Glan Clwyd (YGC)						
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Gill Harris, Executive Director of Nursing and Midwifery/Deputy Chief Executive						
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Matthew Joyes, Acting Associate Director of Quality Assurance						
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO Matthew Joyes, Acting Associate Director of Quality Assurance						
<b>Atodiadau</b> <b>Appendices:</b>	1. Quality Governance Review – YGC 2. Ratings Table (provided for members only as not in public domain)						
<b>Argymhelliad / Recommendation:</b>							
The Quality, Safety and Experience Committee is asked to receive this report for assurance.							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>	✓	<b>Er gwybodaeth For Information</b>	
<b>Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol</b> <b>Y/N to indicate whether the Equality/SED duty is applicable</b>						N	
<b>Sefyllfa / Situation:</b>							
The Quality Governance Review process is designed to provide the service with an honest and supportive assessment of its arrangements and outcomes in relation to the governance of quality (covering patient safety, patient and carer experience, and clinical effectiveness). The primary aim is to drive improvement and to facilitate the sharing of best practice. A secondary purpose is to provide the Health Board with assurance on quality governance within the service, complementing other internal arrangements (such as clinical audit, ward accreditation) and independent or external arrangements (such as internal audit, Healthcare Inspectorate Wales inspections)							
<b>Cefndir / Background:</b>							
This review is the first of its kind in Betsi Cadwaladr UHB and therefore and it is acknowledged the framework and methodology will develop over time. The framework is based around the Welsh Government Health and Care Standards domains with an element of self-assessment adapted from the English Care Quality Commission ratings process. The process consists of data collection, self-assessment by the service, data evaluation by the review panel, further deep-dives where needed, report development and improvement planning.							

As a result of the pandemic, a significantly reduced review methodology was used. For example, on site visits and discussions did not take place and deadlines were extended to allow the site to focus on front line care delivery. This has impacted the scope of the review, and some areas could not be explored fully, however the data and information obtained from corporate and local systems has allowed the findings of this review to be identified and supported by evidence. The evidence obtained has been indexed and archived.

Ysbyty Glan Clwyd was selected as the service for the first review due to concerns expressed by the Health Board regarding quality governance at the site arising from performance and quality information.

## **Asesiad / Assessment & Analysis**

A copy of the full report is provided for the Committee at Appendix 1. In summary: The site is clearly a very busy and active hospital. While the report focuses on areas of concern, there is clearly dedicated staff working hard to deliver high quality care to patients and good practice to be highlighted and shared. This reflected in the overall positive feedback reported by patients, carers and visitors. However, the areas of concern highlighted in this report are significant.

These concerns can be grouped into two areas:

1. Management control and governance
2. Sustainable improvements

A number of recommendations have been made to support the site with improvement. Many of these actions require support from the Health Board. In particular, the most significant recommendations include the development of an improvement plan, engagement plan, workforce plan, alongside a review of governance and risk management arrangements. It is the strong view of the review that piecemeal actions are not appropriate and a long term improvement plan is needed for the site to make the necessary changes in a sustainable way. The success of this plan will require the contribution and support of the wider Health Board.

Due to the limitations referenced in this report two key areas have not been able to be explored sufficiently to provide assurance or recommendations – these include the site's learning culture (covering how lessons are identified, learned and translated into sustainable improvements) and the improvement culture (covering quality improvement capacity, capability and utilisation). There is significant corporate work underway to make improvements in these areas and the site should remain actively involved in those.

The management team of the site were asked to submit a self-assessment and information submission in advance of the review. The self-assessment asked the team to assess the site against the domains of the Health and Care Standards using a four point scale as follows:

- Significant Issues - A rating of Significant Issues indicates the site/division is performing poorly against the Health and Care Standards for that domain, with significant risks to quality
- Improvement Needed - A rating of Improvement Needed indicates the site/division is not meeting all the Health and Care Standards for that domain, however there are clear improvement plans which can be evidenced and limited risk to patients, staff and the organisation.
- Good Practice - A rating of Good Practice would indicate the site/division is meeting the Health and Care Standards for that domain.

- Outstanding Practice - A rating of Outstanding Practice would indicate the site/division is meeting and exceeding the Health and Care Standards for that domain and has areas of exceptional practice.

The review process did also provide its own ratings based on evaluation of the evidence, however, as this is the first review of its kind within the Health Board, these ratings have not been included in the report for fairness due to the lack of comparison. Future reviews will provide the rating as standardisation/moderation will be able to take place to ensure the ratings are robust. This is in-keeping with other such methodologies that were used to inform this process, i.e. the Care Quality Commission (CQC) ratings process. A copy of the review ratings are provided at Appendix 2 for Committee members only for information.

It should be noted that the review process encountered numerous difficulties in collecting and collating information - different systems, all coded differently, with data quality concerns and with varying levels of access and responsiveness. There is no doubt that leaders at the site also experience these very same issues in trying to obtain, analyse and triangulate information to inform their current position and improvements. The Health Board's overall information strategy should consider this feedback and work towards making triangulated and accurate information easier to access for local leaders and staff.

Due to the issues identified and the need to provide robust assurance to the Health Board, a revisit is recommended in 12 months to report on progress.

The Review Panel extends its gratitude and appreciation to the leaders and staff at Ysbyty Glan Clwyd who have engaged with this review, and to the corporate teams who have provided data and analysis in support of the review. This appreciation is even more so due to the unprecedented impact on services from the COVID-19 pandemic and the hard work and dedicated of staff across the service to prepare and respond to the challenges. It is recognised that the pandemic will have impacted upon the service and its staff.

The management team of the site provided an initial action plan in response to the review however this was rejected by the responsible executive director. Since then, there has been significant change in the management team of the site and a number of acting appointments are in place. It is therefore proposed that a new, initial action is developed by the current acting team and a more detailed full plan is developed as new post holders come into place.

The acting management team of the site have a lead starting at the beginning of May who will take forward the development of the initial plan outlines above. The Associate Director of Quality Assurance is meeting with the management team on 29 April 2021 to discuss. The plan will be shared with the Committee once available.

It is important to note however that improvements are already as "make safe" immediate actions whilst the formal plan is being developed, including:

- Incidents that require Make it Safe Reviews and subsequent investigations are led by the directorate teams with support from the relevant directorate governance officer. These are now to be listed in the directorate's Patient Safety Quality (PSQ) report.
- The Business Power Tool information for Infection Prevention reports is now available to all heads of nursing to enable them to view their own wards infections and outbreaks. This informs their Local Infection Prevention Group (LIPG) reports. The report that

informs the Secondary Care Infection Prevention Control (IPC) Forum is co-written by the site director of nursing (area and acute) and the lead IPC nurse for central.

- Any report provided to the Health Inspectorate Wales is now reported via LIPG and the Central PSQ.
- Nursing staff use a risk-based approach to planning care with a range of risk assessments undertaken including falls, pressure risk and infection control, these are managed via the heads of nursing who undertake a programme of audits documented in the IRIS electronic system. This is now reported by the directorates through their PSQ reports.
- There is improved and consistent attendance at Central Safeguarding meetings and includes reports and attendance from other divisions based on YGC site but managed by other divisions across BCUHB: Cancer services, Mental Health & Learning Disabilities, Women's, Children's.
- The Safeguarding Team have, in response to the issues raised by them in the governance review devised a draft action plan to address identified issues. The Emergency Department (ED) has recruited a dual trained Registered Nurse (RN) (adults and paediatric qualified) with special interest in children's safeguarding. The Specialist Practitioner in Paediatric Safeguarding works with staff in ED to improve compliance with completed forms. Targeted training is planned to address this with Matron and Safeguarding team.
- Any IPC report requiring an action plan is ratified through LIPG. Both area and acute have prepared an IP Plan on a Page for the next 12 months which is being taken through the governance route to Central LIPG then IPC Forum secondary care.
- NICE guidelines and standards are now reviewed as part of the business of the site's clinical effectiveness group which meets monthly, chaired by the associate medical director for quality and safety. Clinical leads from each of the three Hospital Management Team (HMT) directorates are held to account for the submission of the compliance data.
- The site is the pilot for the roll out of the Medical Examiner service in North Wales. The site medical director and associate medical director for quality and safety are working closely with the Medical Examiner's Office and the Clinical Effectiveness team to deliver meaningful scrutiny of and learning from deaths.
- Plans in place to introduce a Workforce Partnership Forum to ensure regular dialogue with trade union partners.
- The quality governance review has enabled the Site Director of Nursing to undertake a mini review of the reporting of the site into the secondary care fora. The Interim Director of Governance is supporting a full review of site governance structures.
- The change of reporting from the 'issues of significance report' has been replaced by the Chair's Report (Triple AAA) report format. This now distils previously disparate information into succinct bullet points for discussion at the secondary care fora.
- The Acute Site Director has reviewed and restarted the risk management meeting.

**Strategy Implication** – Not applicable. Paper does not relate to strategic or business plans.

**Options considered** - Not applicable. Paper is not an options appraisal.

**Financial Implications** – Not applicable. Paper does not relate to financial expenditure.

**Risk Analysis** – This is contained within the report.

**Legal and Compliance** – This is contained within the report.

**Impact Assessment** – Impact assessments are not required for this report.





## Quality Governance Review (QGR) – Report

<b>Division/Site:</b>	Ysbyty Glan Clwyd
<b>Date of Review:</b>	September - October 2020
<b>Chair of Review:</b>	Debra Hickman, Acting Executive Director of Nursing and Midwifery (to January 2021)
<b>Quality Governance Lead for Review:</b>	Matthew Joyes, Acting Associate Director of Quality Assurance
<b>Version</b>	2.0

## INTRODUCTION

Betsi Cadwaladr University Health Board (the Health Board, or BCUHB) is the largest health organisation in Wales, with a budget of £1.3 billion and a workforce of 17,000 staff, providing primary, community, mental health and acute hospital services for the population of North Wales.

The Quality Governance Review process is designed to provide the service with an honest and supportive assessment of its arrangements and outcomes in relation to the governance of quality (covering patient safety, patient and carer experience, and clinical effectiveness). The primary aim is to drive improvement and to facilitate the sharing of best practice. A secondary purpose is to provide the Health Board with assurance on quality governance within the service, complementing other internal arrangements (such as clinical audit, ward accreditation) and independent or external arrangements (such as internal audit, Healthcare Inspectorate Wales inspections).

This process and this report makes no critical comment about or towards individuals. It is entirely focused on the quality outcomes for patients, carers, visitors and staff and identifies system-level management and governance issues which are needed for improvement. Equally, it is important to note the issues identified in this review may be beyond the service's own ability to resolve.

The Review Panel extends its gratitude and appreciation to the leaders and staff at Ysbyty Glan Clwyd who have engaged with this review, and to the corporate teams who have provided data and analysis in support of the review.

This appreciation is even more so due to the unprecedented impact on services from the COVID-19 pandemic and the hard work and dedicated of staff across the service to prepare and respond to the challenges. It is recognised that the pandemic will have greatly impacted upon the service.

It was recognised that a new Site Acute Care Director had been appointed and a new interim Site Nurse Director was in post at the time this report was initially finalised, and since then further changes have occurred in the Hospital Management Team (HMT). This report is therefore presented to support them to continue the improvement journey at the site.

## METHODOLOGY

This review is the first of its kind and it is acknowledged the framework and methodology will develop over time.

The framework is based around the Welsh Government Health and Care Standards domains with an element of self-assessment adapted from the English Care Quality Commission ratings process.

The process consists of data collection, self-assessment by the service, data evaluation by the review panel, further deep-dives where needed, report development and improvement planning. The data collected came from a variety of sources including ESR<sup>1</sup>, Datix<sup>2</sup>, CRT ViewPoint<sup>3</sup>, along with a variety of locally developed systems and spreadsheets. The self-assessment asked the service to

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<sup>1</sup> ESR is the human resources management used in the NHS

<sup>2</sup> Datix is the safety and risk management system used within the Health Board

<sup>3</sup> CRT ViewPoint was the patient feedback system used in the Health Board until 2020

provide data and narrative, alongside a self-rating against each domain of the Health and Care Standards<sup>4</sup> from four options:

- Significant Issues - A rating of Significant Issues indicates the site/division is performing poorly against the Health and Care Standards for that domain, with potentially significant risks to quality.
- Improvement Needed - A rating of Improvement Needed indicates the site/division is not meeting all the Health and Care Standards for that domain, however there are clear improvement plans which can be evidenced and limited risk to patients, staff and the organisation.
- Good Practice - A rating of Good Practice would indicate the site/division is meeting the Health and Care Standards for that domain.
- Outstanding Practice - A rating of Outstanding Practice would indicate the site/division is meeting and exceeding the Health and Care Standards for that domain and has areas of exceptional practice.

The review panel did not award ratings to the domains due to the impact on the review process from the pandemic.

As a result of the pandemic, a significantly reduced methodology was used. For example, on site visits and discussions did not take place and deadlines were extended on several occasions to allow the site to focus on front line care delivery.

The report, once checked for factual accuracy and approved by the Chair of the review will be presented to the Patient Safety and Quality (PSQ) Group alongside the improvement plan and also to the Quality, Safety and Experience (QSE) Committee of the Health Board. Actions within the improvement plan will be monitored by the Corporate Quality Assurance Team and reported to the PSQ Group through the Quality Assurance Report, and onwards thereafter to the QSE Committee.

Recognising the current pandemic, a small number of recommendations have been produced to provide the site with a manageable number of high impact areas for focus.

## ABOUT THE SERVICE

Ysbyty Glan Clwyd is a district general hospital in Bodelwyddan, Denbighshire. The service is one of three sites within the Secondary Care Division of the Health Board and provides a range of acute secondary care services with the exception of paediatrics, women and maternity services, radiology/pathology and cancer services which are part of separate directorates or divisions. However, the directorates within the site do support these services and the nursing and medical workforce are professionally accountable to the Site Nursing Director and Site Medical Director.

The leadership of the site is from a Site Acute Care Director, supported by a triumvirate of Site Medical Director, Site Nursing Director and Site Hospital Director. A site governance team supports the quality agenda. A triumvirate model of Directorate General Manager, Clinical Director and Head

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<sup>4</sup> Welsh Ministers are permitted (Section 47 of the Health and Social Care (Community Health and Standards) Act 2003), to prepare and publish statements of standards in relation to the provision of health care by and for Welsh NHS bodies. The Health and Care Standards (2015) form the cornerstone of the overall quality assurance system within the NHS in Wales alongside the Framework for Assuring Service User Experience (2013).

of Nursing supported by a Governance Facilitator leads each of the three directorates (Emergency Care; Medicine; Anaesthetics, Surgery and Critical Care).

The hospital opened in 1980 and a significant refurbishment programme commenced in 2011 and completed in 2018.

## **RATIONALE FOR THE REVIEW**

Ysbyty Glan Clwyd was selected as the service for the first review due to concerns expressed by the Health Board regarding quality governance at the site arising from performance and quality information.

This included concerns regarding infection control, a number of serious incidents and a particular Never Event, the number of white wards (through the Ward Accreditation process), a critical finding from the Welsh Risk Pool and a lack of assurance from the site to executive leaders. Additionally, Board Members reported a number of concerns raised with them from the community.

## **REVIEW TEAM**

Each Quality Governance Review has a Chair, a Quality Governance Lead and a Review Panel. Collectively the panel have gathered and considered the available evidence.

The Chair of this review was Debra Hickman, Acting Executive Director of Nursing and Midwifery (to January 2021) (substantively Secondary Care Director of Nursing).

The Quality Governance Lead for this review was Matthew Joyes, Acting Associate Director of Quality Assurance (substantively Assistant Director of Patient Safety and Experience). They were supported by Anne Hall, Head of Quality Assurance and Erika Dennis, Senior Quality Assurance Manager.

The review panel included:

Justine Parry – Assistant Director of Information Governance and Risk Management

Dr Kate Clark – Acting Deputy Executive Medical Director (substantively Secondary Care Medical Director)

Dr Melanie Maxwell – Senior Associate Medical Director and Improvement Cymru Clinical Lead

Michelle Denwood - Associate Director of Safeguarding

Reena Cartmell – Associate Director of Nursing

Lynne Grundy – Associate Director of Research and Innovation

## **FINDINGS: STAYING HEALTHY**

**The service rated themselves for this domain as: Good Practice.**

### Health and Safety

The site has a health and safety meeting chaired by a Directorate General Manager.

Over the last 3 years, the site reported 148 incidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). The reporting numbers are fairly consistent with the exception of staff positive COVID-19 incidents which affected all services.

During the COVID-19 pandemic, a member of staff working at the site contracted COVID-19 and sadly passed away after receiving care at the site. An investigation into this found that the staff member had not received face fit testing despite being identified as needing it, working with aerosol generating procedures and being seen to be wearing FFP3 masks – whilst this cannot be confirmed as contributory it highlighted a significant gap in oversight of face fit testing. It is however believed this is an organisation-wide issue arising from the lack of a central recording and follow up system. Fit testing is now done on portacount machines which record the name, date and test outcome and since October over 1,100 staff have been tested.

### Health Promotion

The site provides nutritional information on menu cards and participates in the Health Meals initiative in the canteen.

The site is non-smoking however compliance is variable. Local authority enforcement support is being progressed. Television screens in some waiting rooms promote stop smoking and outpatient staff link with Smoke Cessation Wales.

### Food Hygiene

Following an unannounced inspection by Denbighshire Council Food Safety Officers in February 2020, it was found that a number of fridges located at ward level at the site were not being managed in compliance with the Food Safety Act. A “ward kitchen” relates to a small area, which typically has a kettle, toaster and fridge, where patient food may be prepared and stored at ward level. This affected the overall Food Hygiene Rating for the hospital, which was reassessed as level one when previously the score was level four. In response, the site conducted an audit of fridges of this type (and wider across the Health Board) and have strengthened processes for checking fridge temperatures.

In 2015, a number of issues were identified in the Catering Department at the site (Operated by the Estates and Facilities Division) resulting in a rating score of two.

## **FINDINGS: SAFE CARE**

### **The service rated themselves for this domain as: Improvement Needed.**

#### **Patient Safety**

The site report that concerns are handed over in Safety Briefs, Safety Huddles and Daily Datix Reviews by the Heads of Nursing. The site report this is supported by weekly governance scrutiny sessions, the use of WHO checklists in theatres and through directorate WhatsApp groups.

The site report that lessons learned and safety alerts are cascaded through site meetings such as the quality group, Local Infection Prevention Group (LIPG), matrons and ward manager meetings, consultants meetings and MDT weekly meetings.

Nursing staff use a risk-based approach to planning care with a range of risk assessments undertaken including falls, pressure risk and infection control, these are managed via the Heads of Nursing who undertake a programme of audits documented in the IRIS electronic system. This is now reported by the directorates through their Patient Safety and Quality (PSQ) Group reports.

From discussions with key staff, it is clear there has been a reliance on the Site Governance Team to drive forward patient safety responses and improvements. This risks removing ownership and clinical leadership from directorates within the site and overloading the small governance team (as seen with issues affecting pressure ulcer reporting detailed later in this report).

#### **Safeguarding**

Between October 2019 and September 2020, there have been twenty five (25) Adult at Risk reports submitted in relation to YGC.

13 of these reports were generated from community services due to concerns about potential unsafe discharges from YGC. However, the Local Authority (LA) who lead on the Adult at Risk process were in agreement, following initial enquiries, with the professionals involved in these respective cases that all 13 of the reports could be closed to the Adult at Risk process as no safeguarding concerns, specific to potential abuse or neglect were identified.

Of note, there has been an increase in unsafe discharge reporting during the COVID-19 period and this is reflected across all three hospitals.

4 reports highlighted potential concerns specific to Healthcare Acquired Pressure Ulcers. The LA agreed on discussion with those involved in the patients' care and treatment that these reports could be closed to the Adult at Risk process. Of the reports;

1 was deemed as inappropriate to the Adult at Risk process as it did not meet the threshold and the other concluded that all care had been provided as per the Wales Safeguarding Procedures.

2 further cases progressed to a Strategy Meeting whereby nursing documentation at the site evidenced that both individual patients had been admitted with pressure ulcers (the concern was subsequently in relation to care provided prior to admission).

4 reports related to the potential neglect of patients at the site. One case was closed following further enquiries, two cases were closed following Strategy Meetings where evidence was produced to demonstrate actions taken, and one case remains open to the Adult at Risk process with agreed actions in place.

The Protection Plans and Risk assessments do occasionally lack detail which subsequently result progressing to a strategy meeting. Improved quality of information and detail could avoid the need to call a strategy meeting.

1 report related to concerns that site staff had raised in relation to a family member. This was closed to the Adult at Risk process following further enquiries as there was no evidence that abuse or neglect had taken place.

3 reports were generated by site members of staff due to safeguarding concerns taking place in the community. All cases were investigated and subsequently closed to the Adult at Risk process.

Site staff engage fully with the Adult at Risk process, Matrons are attending Strategy Meetings and contribute very effectively. Site staff contact the Corporate Safeguarding team to discuss cases of concern and seek advice and support. Risk Assessments and Protection Plans are generally of a very good standard.

Overall the quality of reports, as assessed by the Corporate Safeguarding Department, range from good to very good. Protections Plans and Risk Assessments should be submitted with the Adult at Risk reports where appropriate. Unfortunately, this is not always the case and the documents are completed and submitted upon request from Safeguarding Specialists, Corporate Safeguarding Team. The Safeguarding Specialists are addressing this through 1:1 and group supervision and it has also been escalated within the Safeguarding Forums.

In general, the quality of reports varies from satisfactory to very good. The quality of Child at Risk reports generated from ED however, are a cause of some concern. Of note, the cases where there are concerns in relation to the quality of safeguarding reports, these do not relate to those cases reviewed under the Cardiff & Vale process. The issue has been raised with the Head of Nursing and ED Manager. Corporate Safeguarding do regularly return reports and or request additional information or request retrospective reports. It has to be noted that the nature of the activity and acuity in ED might be a contributory factor in terms of the quality of the reports being submitted. However, senior members of staff should be quality assuring the reports before submission.

There have been two hundred and twenty nine (229) Child at Risk reports from the site between October 2019 and September 2020. 54% (n=124) of these reports were from the Emergency Department. The main themes of abuse identified from the Child at Risk reports are neglect in the younger aged children and emotional abuse for the older aged children. There have been no Child at Risk reports generated as a result of any abuse or neglect of children whilst receiving care at YGC. All the reports relate to concerns site staff have identified re potential harm occurring in the family home or community.

There have been 4 cases within the set timeframe where concerns have been raised around potential professional concerns. 3 cases were closed by the LA as they did not meet the threshold of a Section 5 and no safeguarding concerns raised. One case was concluded to have been in relation to poor practice. Site staff engage fully with the Section 5 process with attendance at Strategy Meetings and providing relevant information. Site staff also support the individual members of staff and develop risk assessments that directly address patient safety and staff well-being.

The Corporate Safeguarding Department provide the Health Board with assurance against both Regional and National published Child Practice Reviews. A recommendation from the Cardiff and Vale CPR – “The Accident and Emergency Department have weekly safeguarding meetings to consider head injuries and burns in children aged under one. This was extended to include fractures in children aged under two years old.” This activity was piloted in the Emergency Department (ED) in YGC from February – April 2019 and fully evaluated in July 2019. The successes of the pilot included:

- Greater awareness of safeguarding policies and procedures
- Increased engagement with the Safeguarding Team, both in person and by telephone
- Awareness of the escalation process when concerns are identified
- Improved quality of referrals being submitted, although these may not necessarily be relating to cases forming part of the weekly ED Safeguarding review process
- Assurance that YGC ED are complying with Recommendation 3 of the C&V CPR

The recommendation from the pilot was to continue with the current activity in YGC ED and to extend the activity to the East and West ED's. A regional audit will take place and the findings will be documented in the six monthly Corporate Safeguarding Report (Q1 & 2) and subsequently in Q3 & 4.

There have been no key specific incidents, which have resulted in any lessons learnt from Child Practice Reviews relating to YGC practice and process.

A recent DHR (unpublished) gives early recommendations that Routine Enquiry Domestic Abuse (RE DA) was not carried out when the victim accessed the ED in YGC. The potential lack of RE DA across all three ED's has recently been highlighted in the Corporate Safeguarding Governance and Performance Group (SGPG). An action was agreed for a task and Finish Group to be developed to obtain assurance and to strengthen governance and reporting across all sites.

There have been no key specific local incidents which have resulted in any actions directed at YGC practice and process.

Trauma Risk Management (TRiM) is a peer-led process that seeks to identify and assess the psychological risk to individuals who have experienced trauma in the course of their work. Early identification of staff exposed to trauma, aids to promote a healthy workforce, by supporting the welfare needs of staff, and contributes towards reducing staff absence. The process was launched in May 2020. Site managers are already beginning to engage by appropriately referring their staff to the TRiM team. This is an excellent supportive measure and highlights the recognition of staff health and well-being by YGC management.

In 2019-2020, 14 PRUDiC's have taken place across BCUHB. Half of these (50%) have taken place in Central. The unexpected deaths were caused by a range of incidents/accidents so no themes/trends can be identified. The PRUDiC process has now concluded for all these cases from 2019-20. Site staff engaged fully in the PRUDiC process through providing timely and accurate information and attending PRUDiC meetings. This ensures the sharing of up to date information.

There has been 71 applications for DoLS from YGC over the last 12 months (Oct-19 to Sep-19). There is a distinct increase in the number of applications submitted in Q2 2020-21. Table 1 below highlights the number of applications submitted from YGC along with the number of forms that had issues. These issues included incomplete patient details on application forms, no capacity (specific) forms attached or completed, no Care and Treatment Plan (CTP) documentation included, poor or



wrong decision making on capacity (specific) forms, and missing details regarding general communication and medical information.

**Table 1**

YGC DoLS Applications		Applications	Issues with Forms
<b>2019-20</b>	<b>Q3</b>	<b>14</b>	11
	<b>Q4</b>	<b>14</b>	14
<b>2020-21</b>	<b>Q1</b>	<b>17</b>	15
	<b>Q2</b>	<b>26</b>	22

Of the 71 DoLS applications submitted between October 2019 and September 2020, 62 (87%) of them contained some issues/concerns that resulted in them having to be returned to the applicant. This could have led to a delay in the authorisation of a DoLS, which in turn, may have resulted in the patient having been detained illegally.

Of the 71 applications, 16 (23%) were deemed to have contained major issues in preventing their authorisation. 66 (93%) of the DoLS applications were subsequently withdrawn (reasons given in table 2 below), three (3) were granted a DoLS and two (2) are currently being processed.

**Table 2**

Applications	Withdrawn
Discharged (Hospital)	51
Regained Capacity	5
MHA	3
Discharged Prior to Full Assessment	3
Died	2
Discharged Prior to Form 5 Completed	1
Patient to be Discharged in <5 days	1
<b>Total</b>	<b>66</b>

The ward specific origin of the DoLS application is recorded in Table 3 and provides a breakdown of the DoLS applications and the concerns/issues with the forms.

**Table 3**

Issues with applications	Major Issues	Minor Issues	No Issues	Total
Ward 9		7		7
Ward 1	4	6	1	11
Ward 12	3	6	1	10
Ward 8	1	4	1	6
Ward 2	2	4		6
AMU		4	2	6
Ward 11		3		3
Ward 7	2	3		5
Ward 4	2	3		5
Ward 19		3	2	5
Rupert		1		1
Ward 14		1		1

Ward 5	1	1		2
ED	1			1
ICU			1	1
ITU			1	1
<b>Total</b>	<b>16</b>	<b>46</b>	<b>9</b>	<b>71</b>

There has been excellent engagement from the site in relation to the Safeguarding Ambassador role. There are currently 11 ambassadors at YGC with representation from ED, Medical Secretarial, Medicine, Surgery, Ophthalmology, Theatres. All have attended the ambassador training and engage regularly with their First Point of Contacts within the Corporate Safeguarding Department. The Ambassadors are also engaging well with the newly developed Group Supervision sessions facilitated by Corporate Safeguarding.

Following a review of a Ward Accreditation Award, it was identified that additional Safeguarding information was required to support the Ward Accreditation Reviewers in their assessments. The Corporate Safeguarding Department have compiled safeguarding information reports which are available for the aligned visits to the identified wards. Since the Corporate Safeguarding Team's involvement YGC have had two accreditations carried out.

The purpose of the Area Safeguarding Forums is to ensure safeguarding practice, within the geographical area of responsibility, has not only implemented the strategic agenda set by the Corporate Group, and ultimately the Board, but is actively engaged in the Safeguarding People at Risk of Harm agenda including reporting, auditing and evaluating practice. The Director of Nursing, YGC, currently chairs the Central Area Forum. Prior to this the responsibility was shared between the Medical Director YGC and Area Medical Director Primary & Community Care. During the reporting timeframe there were 7 scheduled meetings, 2 of the meetings had been cancelled. The first meeting cancelled was in response to COVID-19 lockdown measures. A further meeting was cancelled on the 30.09.2020 because of administration difficulties and acuity within the hospital. The Area Safeguarding Forum relies on commitment from all services and a robust engagement to ensure we deliver on the key purpose and function. Unfortunately, there have been a number of changes in chairing and vice chairing arrangements over the past 12 months, which has resulted in some inconsistency. YGC have an extremely valuable contribution to make and it is imperative that all the Divisions are represented at the meeting. The forum has lost some momentum due to the need to cancel 2 of the meetings and the delay in the sharing of minutes from the July 2020 meeting. As a result the action log has not been reviewed and updated with the forum members since July 2020. On the 25.08.2020 The Chair, Vice Chair and Area Safeguarding Manager met to discuss the purpose and function of the Safeguarding Forum and agree the mandatory fields. This was a very positive and engaging meeting and it was agreed that the forum focused more on data reporting and policy driven and needed to be more service driven. The Terms of Reference, agenda and reporting template and arrangements were reviewed and changes agreed. The attendance at the forum was also discussed and it was agreed that all Heads of Nursing would attend to ensure all directorates within YGC are represented. A 12-month work plan is to be developed to keep the focus on key issues. The Chairs and or Vice Chairs of the Safeguarding Forum attend the SGPG and present an Issues of Significance report for further discussion. Attendance has been inconsistent from the agreed representative of the Central Safeguarding Forum, and to date an Issues of Significance report has been prepared and submitted by the Area Safeguarding Manager. This position will require strengthening moving forward and a report to be submitted by the Chair.

## Infection Prevention and Control

The number of healthcare acquired infections has remained largely consistent. Between March 2019 and October 2020, the average number of e.coli cases per month is 4, c.diff cases is 3, klebsiella is 1, and MSSA cases is 2. There have been 3 MRSA cases in this timeframe (the last in March 2020).

Compliance with the 1 hour Sepsis Screening Bundle in ED is reported at 66% in August 2020 and for inpatients is reported at 100% (although there are accepted data quality issues with the measurement for inpatients across the Health Board).

Bare below the elbow compliance is reported at 100%.

The site reported that they implemented COVID-19 related infection prevention and control measures in line with Health Board standards. This was detailed to Healthcare Inspectorate Wales during their most recent Quality Check inspections to the site.

During a HIW Quality Check in August 2020 of Ward 11, HIW saw evidence of an internal IPC audit that was conducted by the Corporate Infection Prevention and Control Team in July 2020. The local audit highlighted a number of issues, some of which were contrary to the evidence provided to HIW in the self-assessment. HIW considered this evidence in conjunction with the verbal responses made in the Tier 1 telephone call and further written evidence provided following the call. Their concerns were that no action plan had been produced in response to the audit and evidence of remedial action had only been provided on a piecemeal basis for a small number of the issues identified by the audit. Therefore only limited assurance was available that remedial actions had been put in place and that any learning had been shared following the audit. HIW also found insufficient evidence that actions taken in response to the issues raised in the IPC audit had been submitted to the local IPC group, and that no follow-up had been undertaken by the local IPC group. Therefore, HIW were not assured that the site's governance mechanisms provided sufficient oversight of this matter and ensured that audit activity is responded to robustly and learned from.

The Power BI Tool for infection prevention reports is now available to all Heads of Nursing to enable them to view their own wards infections and outbreaks. This informs their reports to the Local Infection Prevention Group (LIPG). The report that informs the Secondary Care IPC Forum is co-written by the Site Director of Nursing and the lead IPC nurse for central.

## Incidents

Overall incident reporting at the site has remained largely consistent, with the exception arising from the COVID-19 impact which saw a reduction in patient safety incidents associated with reduced and changed activity, and an increase in staff related incidents from COVID-19 positive results. This pattern was seen across the Health Board and nationally.

During the last two years, the site reported 86 serious incidents. A serious incident is defined as an incident (not exclusively a patient safety incident) that occurred in relation to NHS funded services and care resulting in the unexpected or avoidable death of one or more patients, staff, visitors or members of the public; or permanent harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy. The impact of COVID-19 makes longer term comparisons difficult; if the effect of COVID-19 on reporting levels was adjusted then it could be suggested an overall increase in serious incidents has occurred but this is a hypothesis.

During the last two years, the site reported 5 Never Events. Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. Three occurred in anaesthetics (two wrong site blocks and one retained object) and critical care and two in surgery (one wrong side block and one wrong site surgery). An external review is outstanding for the wrong site surgery Never Event.

In mid-2020 it emerged, as a result of a Welsh Government and HIW enquiry, that the site had not been reporting pressure ulcer incidents as serious incidents in accordance with national and local requirements between April 2019 and September 2020. Following investigation, 17 incidents were not reported correctly (with 10 having been reported correctly). In 4 cases, the all-Wales pressure ulcer review tool had not been completed fully or stored in the correct files. The investigation identified a lack of clinical ownership of incidents and learning, and a reliance on the Site Governance Team to undertake key tasks (which has itself become single person dependent). Improvements have been made since including Heads of Nursing taking responsibility for pressure ulcer review panels.

### Safety Alerts

No safety alerts are overdue at the time of writing, however there is an outstanding alert covering all of the Secondary Care Division relating to the introduction of the National Safety Standards for Invasive Procedures. This alert has clear links to Never Events occurring at the site.

### Medication Safety

There is highly variable levels of completion for the monthly all-Wales Medication Safety Monitoring Audit which is completed by Pharmacy staff. For those areas of completion, there is variable performance. For example in the last three months, the proportion of patients with medicine allergy status documented on the drug chart (including known allergies) is consistently high whereas the proportion of patients with medicines reconciliation undertaken within 24 hours of admission is generally lower (some as low as 33% compliance) and patients who were given all appropriate medication doses in the last 24 hours (some as low as 30% compliance). Similar issues are occurring across the same wards.

There is variability in how this data is used by ward staff. The newly appointed Medicines Management Nurse is now working with the Heads of Nursing to provide quarterly reports for each of their areas. These are fed into the PSQ Group. In addition Secondary Care also PSQ receives bi-monthly reports.

Medication reconciliation depends on support from the Pharmacy Department which sits within the Central Area Division. The site has expressed concerned about the lack of regular pharmacy cover to some wards.

### Coroner

As a result of COVID-19, there has been significant disruption to the holding of inquests including the adjournment of all in-person inquests for the last 9 months. In the last two years the site has

received two Prevention of Future Death (Regulation 28) Notices. The first notice (inquest heard in 2019) related to ambulance handover delays and the impact on patients safety and access to emergency care. In response the Health Board outlined work underway to address delays. As seen from the Timely Care section below, significant delays remain. The second notice (inquest heard in 2020) related to corporate recruitment practices and a corporate response was issued. An update on actions is awaited from Corporate Workforce and OD and remains four months overdue.

### Litigation

Over the last 2 years, 48 liability claims were received against the site evenly split between personal injury and clinical negligence claims. As with most other areas, COVID-19 has impacted on the number of claims during 2020.

In early 2020 evidence to support a redress claim was requested from within the Emergency Care Directorate of the site. Despite several requests over a long period, no information was provided. The Welsh Risk Pool Committee (WRPC) requested that the Legal and Risk Services Department Safety and Learning Team conduct a review to confirm that an effective governance system was in place within the directorate to ensure that any such events were managed appropriately, and that learning was shared and embedded into practice. Reimbursement of all claims and redress cases was deferred until assurance had been provided. The department senior staff have taken the WRP interventions and review process extremely seriously and worked hard to find a solution. Using the Microsoft Teams application, a system and process has been initiated which provides a sound communication platform and the ability to communicate, allocate responsibility, action and monitor governance issues. Staff were appreciative of the manner in which it works and the information it provides. Handover and teaching programmes share the learning and an audit trail to confirm this is in place. Benchmarking, action plans and learning events flow from the process. It is hoped that the system can progress further and be shared more widely, and recommendations have been made in this respect. Substantive consultant and middle grade medical staffing has improved, with consequently less reliance on locum staff and the ability to share governance and administrative responsibilities. The WRP review by the L&R Safety & Learning Team now recommend that there is Substantial Assurance that an effective and sustainable governance framework is in place in the Emergency Care Directorate of the site. This good practice has been shared with other directorates and Critical Care are implementing a similar model, with a future presentation planned to the Secondary Care Division.

## FINDINGS: EFFECTIVE CARE

**The service rated themselves for this domain as: Improvement Needed.**

### NICE Guidelines

The Site Clinical Effectiveness Group and Site Associate Medical Director for Quality monitor NICE guideline compliance. Published guidelines are issued to clinicians who respond with a plan for implementation.

The Corporate Clinical Effectiveness Team issued 67 NICE documents to the site dating back to August 2018. 7 have been returned as full compliance, 7 as partial compliance, 35 have had no response and 18 are deemed as not applicable. Of those with no response, the oldest dates to September 2018.

### Outcomes

The site report that they monitor clinical outcomes through the IRIS module, SEPSIS 6 audits, length of stay reviews, antibiotic audits, learning from events like HAPUs and through participation in national registries. Due to limited capacity and restrictions as a result of COVID-19 within the review team, this line of enquiry, along with clinical audit, was not explored further in this review. From reviewing site quality meeting minutes, it is unclear how outcome data is used to drive quality improvements.

The Community Health Council (CHC) has raised serious concerns regarding the quality of the new centralised vascular service. Not all of the vascular services are within the remit of the site however the CHC report paints stark and concerning patient and staff feedback. A task and finish group is in place led by the Acting Executive Medical Director which includes representation from the CHC with an external review by the Royal College of Surgeons planned for 2021. Concerns have also been raised by Health Board members over urology services in relation to recruitment and retention, instability of contracts for complex cancer activity, high numbers of patients waiting for outpatient appointments and long waiting times, and the lack of robotic assisted surgery. An update paper was provided to Board Members by the Acting Deputy Executive Medical Director in September 2020.

### Mortality

The latest data for the site covers January to March 2020. This shows 99.7% compliance with stage 1 mortality reviews, of which 16.7% were referred to stage 2 and 22% of those were completed. The themes identified from these reviews includes:

- NEWS scores not always completed or actioned;
- Doctors to be more specific with conditions/diagnosis for coding;
- Issues with notes – 37.5% report issues with quality of notes;
- DNACPR not countersigned by a consultant.

The site is the pilot location for the Medical Examiner Scheme and early adopters of the mortality review module on Datix. Consultants from all department except urology are now registered for training or have received training.

The backlog is being worked through with support of PA to the Site Medical Director.

Mortality and Morbidity meetings take place within specialties.

## FINDINGS: DIGNIFIED CARE

**The service rated themselves for this domain as: Good Practice.**

### Spiritual Needs

The service reports that spiritual needs are obtained on admission as part of the “What Matters” conversation with access to multi faith professionals and provision of a multi faith room.

### Hydration and Nutrition

The service report the use of the SHINE tool on admission to ED, WASSP nutrition assessments, and on site Nutritional Support Team.

### Carers

The service report carers are welcomed to ward areas and are included in a “This is me” patient passport.

### Welsh Language

The service report staff can be identified through the orange badge scheme and patients are identified with the orange badge on STREAM boards. The service report they are aiming to have Welsh speaking staff on all shifts, have directorate champions and have access to Language Line. Despite this, in 2020, 70.33% of patients responded that they could not always you speak in Welsh to staff if they wanted to. It is accepted COVID-19 may have impacted upon this.

### Patient Feedback

Patient feedback was collected, prior to COVID-19, through patient surveys or the CRT View Point terminals or online form. Due to COVID-19 restrictions, only limited paper and online surveys are currently in use. During 2020, the site has reported an average satisfaction rate of 9.41 / 10 from 782 responses.

In relation to specific questions, the following patient reported experience measures were captured:

- Did the staff introduce themselves to you? Always = 85.80%
- Do you feel you were listened to? Always = 85.42%
- Do you feel you were given all the information you needed? Always = 81.85%
- Did you get assistance when needed? Always = 87.55%
- Were you involved as much as you wanted to be in decisions about your care? Always = 83.27%



- Did staff take the time to understand what matters to you as a person? Always = 85.95%

During the past year, the Patient Advice and Liaison Service have supported 496 queries. Of these, 88 relate to poor communication (18%) and 139 relate to poor coordination of care (28%).

## FINDINGS: TIMELY CARE

**The service rated themselves for this domain as: Significant Issues.**

### Performance

The percentage of those on a waiting list who have been waiting less than 26 weeks is 42% (including gynaecology) against a national target of 95%. Prior to COVID-19 (Feb 2020), this was 75.01%. During the 20 months prior to the review, the service did not achieve the target with its highest performance being in March 2019 (85.39%). There has been no improvement in the 20 months prior to the review with a worsening position and a marked worsening since COVID-19.

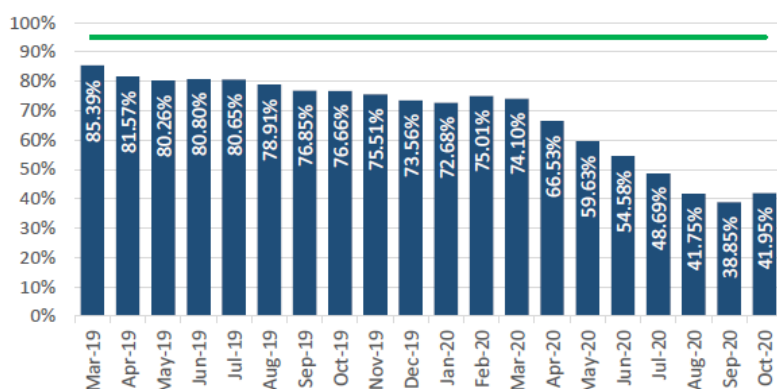


Figure 1 - % of waiting list who have been waiting for less than 26 weeks

14,549 patients were waiting over 36 weeks (including gynaecology which accounted for 702). Prior to COVID-19 (Feb 2020), this was 3,440. There has been no improvement in the 15 months prior to the review with a worsening position and a marked worsening since COVID-19.

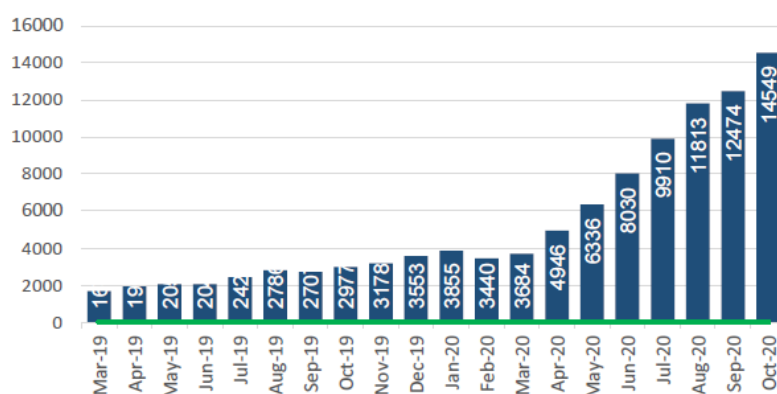


Figure 2 - Number waiting 36+ weeks

4,561 patients were waiting over 52 weeks (including gynaecology which accounted for 276)). Prior to COVID-19 (Feb 2020), this was 658. There has been no improvement in the 20 months prior to the review with a marked worsening since COVID-19.

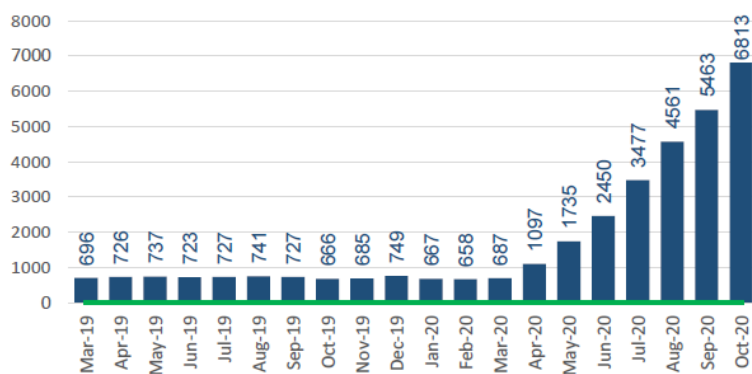


Figure 3 - Number waiting 52+ weeks

The latest percentage of those who spend less than 4 hours from arrival until admission, transfer or discharge is 69.8% against a national target of 95%. During the 20 months prior to the review, the service did not achieve the target except during the COVID-19 lockdown in spring 2020 when attendance reduced significantly. There has been no sustained improvement in the 20 months prior to the review taking into account the COVID-19 effect.

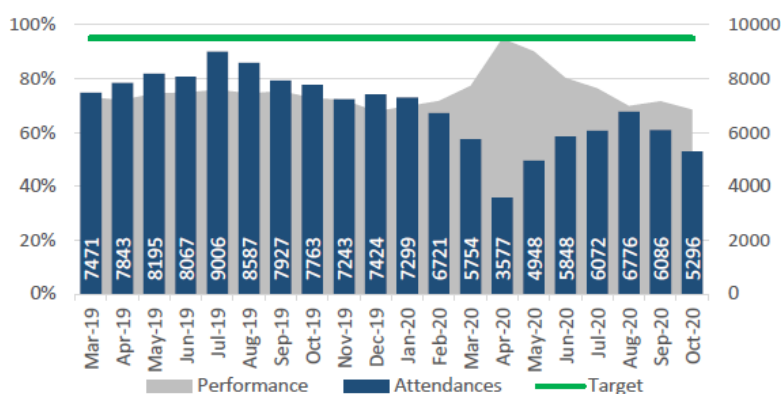


Figure 4 - % who spend less than 4 hours from arrival until admission, transfer or discharge

The service routinely has a high number of patients waiting longer than 12 hours from arrival until admission, transfer or discharge against a national target of 0 except during the COVID-19 lockdown in spring 2020 when attendance reduced significantly. There has been no sustained improvement in the 20 months prior to the review taking into account the COVID-19 effect. In the month prior to COVID-19 (Feb 2020), 759 patients waiting longer than 12 hours. In October 2020 this was 718. The best performance prior to COVID-19 was 632 (in June 2019).

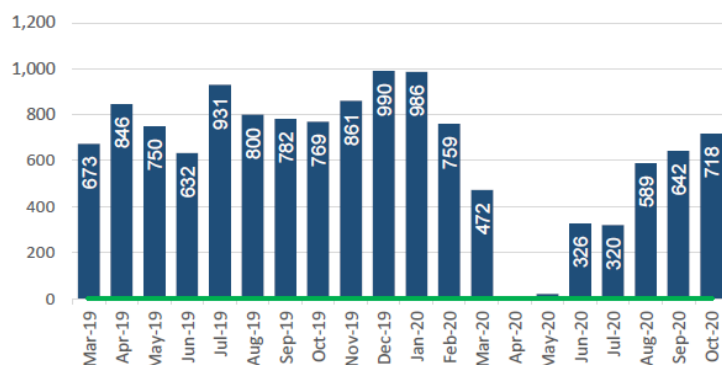


Figure 5 - Patients who spend 12+ hours from arrival until admission, transfer or discharge

Ambulance 8 minute handover compliance is at 65.14%. A significant number of ambulance handovers occur over 1 hour (674 in October 2020) with a worsening position when adjusted for the impact of COVID-19.

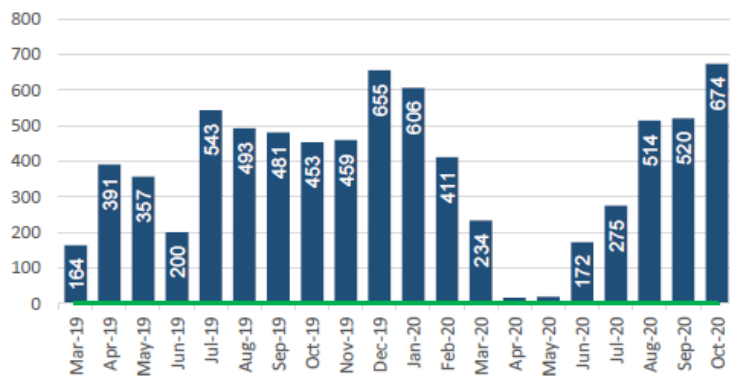


Figure 6 - Number of ambulance patient handovers over 1 hour

The total number of ambulance arrivals over the 20 month period has remained fairly consistent when adjusting for the impact of COVID-19 at around 1,700 arrivals per month.

24.24% of patients diagnosed with a stroke have admission to a stroke unit within 4 hours in October 2020. There has been no sustained improvement in the 20 months prior to the review. 63.89% of patients were assessed by a stroke consultant within 24 hours. There has been no improvement in the 20 months prior to the review with a worsening position and a noticeable worsening since COVID-19.

Improvement is noted in patients who receive a 6 month follow-up assessment rising from 18.20% in December 2018 to 61.30% in June 2020.

## **FINDINGS: INDIVIDUAL CARE**

**The service rated themselves for this domain as: Good Practice.**

### Dementia

The service report their involvement in the butterfly scheme. They report no moves after 8pm to another ward. They also report the COTE services has dementia support workers, “fiddle” boxes and a dementia activity room.

### Learning Disability

The service report the use of the “This is me” patient passport and liaison with the LD Nursing Team.

### Complaints

The overall number of complaints rose from 63 in January 2019, to 129 in June 2019, before reducing to 65 in February 2020 prior to COVID-19 and 39 in August 2020.

The number of complaints receiving a response within 30 days working has improved, from 29.17% in January 2019 to 51% prior to COVID-19 and 85% in August 2020 and 79% in November 2020. Equally, the number of complaints open over 30 days has reduced from 24 in January 2019, 44 in June 2019 to 13 in November 2020. This represents a significant shift from the poorest performing service in the Health Board to the best. It is important the site maintains the strong focus on both the timeliness and number of complaints.

Over the last 2 years 66 complaints progressed to the Public Services Ombudsman for Wales (PSOW). 17 of these progressed to investigations and have been closed at the time of this report, of which 11 were upheld and 6 were not. One of these resulted in a Section 16 Public Interest Report relating to colorectal surgery delays and treatment options, and deficiencies in the complaint investigation. At the time of writing, further reports were expected in relation to colorectal surgery and urology (delayed cancer treatment).

## FINDINGS: STAFF AND RESOURCES

**The service rated themselves for this domain as: Improvement Needed.**

### Safe Staffing

The service report weekly meetings with the Workforce and OD Directorate to monitor roster compliance and a matron of the day to ensure safe staffing.

The service report concerns in the following areas:

- Gastroenterology: only two substantive consultants;
- Junior Medical Rotas: all posts filled but doctors struggling to complete work (a review of workload has been undertaken by Kendall Bluck and findings are awaited);
- Phlebotomy: shortage of staff;
- General Surgery: limited consultants for the on-call roster due to shielding or adjusted duties;
- Emergency medicine consultants: Only five have CCT;
- Shortage of HCSW and registered nurses across the site; particular shortage of B5 nurse in COTE;
- Ward 3 (vascular): currently supported by redeployed nursing staff from Abergele Hospital.

### Vacancies

Workforce data shows a budgeted workforce of 1,904.26 FTE and current workforce numbers at 1,694.79. The highest gaps are as follows (listed by cost code):

- Ward 19 COTE – 9.27
- Ward 3 – 9.86
- Ward 7 – 10.64
- Vascular Ward - 11.65
- Accident and Emergency – 28

The above data is taken from ESR and some data cleaning is needed i.e. Ward 3 and Vascular Ward are the same ward.

The site has the highest registered nurse vacancy factor across the three hospital sites. The site report the issues are at band 5 and band 6 level, with junior support available at both band 6 and 7 level impacting on care and decision making regarding discharges etc.

Site	RN vacancy rate	Band 6 vacancy	Band 5 vacancy
WMH	20%	2.8%	30%
YGC	21%	16.5%	26%
YG	7.7%	1.8%	10%

## Turnover

Overall turnover for the site is 6.89%. The highest areas by cost code are:

- YGC Matrons – 33.56%
- Ward 4 Cardiology – 25.80%
- YGC Vascular Ward – 43.82%

As these are percentage based figures the figures may be disproportionately affected by small numbers of staff within these teams.

## Sickness

Sickness rates have remained largely consistent, excluding COVID-19, over the 20 months prior to the review. In January 2019 the rate was 6.22% dropping to 5.63% in February 2020 and 5.77% in August 2020. A number of wards have sickness over the site figure including:

- Ward 8 Colorectal - 6.12%
- Ward 4 Cardiology – 6.76%
- Ward 12 Renal – 6.98%
- Surgical Assessment Unit – 7.02%
- Ward 3A – 7.10%
- Ward 19 COTE – 7.25%
- SDEC – 7.81%
- Ward 8 Gastro – 7.82%
- Clinical Governance – 7.86%
- Site Managers – 7.99%
- Ward 11 Respiratory – 8.14%
- Vascular Ward – 8.51%
- Matrons – 8.96%
- Accident and Emergency – 9.00%
- Ward 3 – 9.32%
- Coronary care – 9.51%
- AMU – 10.47%
- DOSA – 11.40%
- Ward 3B – 14.53%

As these are percentage based figures the figures may be disproportionately affected by small numbers of staff within these teams. The above data is taken from ESR and some data cleaning is needed; some wards listed here are in effect the same (i.e. Vascular Ward, Ward 3A, and Ward 3B).

## Mandatory Training

Mandatory training compliance has remained largely consistent, excluding COVID-19, over the 20 months prior to the review and is below target (85%). In January 2019 the rate was 79.26% rising to 80.34% in February 2020 and 81.17% in August 2020.

The figures for mandatory training vary with 23 teams (by cost code) reporting compliance below 70% including:

- YGC Vascular Medical Staffing – 20.66%
- Medicine Rotating Junior Medicine – 21.21%
- Medical - YGC Urology – 26.26%
- Gastro Snr Medical YGC – 31.82%
- YGC Breast Surgery Medical – 31.82%
- Medical - YGC Gen. Surgery – 42.42%
- Tracheostomy Nurse – 45.45%
- Orthodontic Administration - 50.00%
- Medical - YGC E.N.T – 51.05%
- Medical – Orthopaedics – 51.42%
- YGC Ward 3A (was Ward2A) – 54.55%
- Medical - YGC ATIC – 55.84%
- Medical - A & E – 57.40%
- Renal Snr Medical YGC – 57.58%
- Urology Oncology Nurse – 59.09%
- Medical YGC Orthodontics – 60.61%
- General Medicine (AMU) Snr Medical – 63.64%
- YGC SC Advanced Nurse Practitioners – 63.64%
- Maxillo Facial Administration – 66.67%
- Medical - Maxillo Facial – 67.42%
- Surgical Management Admin – 67.83%
- YGC Vascular – 68.18%
- Cardiology Snr Medical YGC – 68.94%

As these are percentage based figures the figures may be disproportionately affected by small numbers of staff within these teams. The above data is taken from ESR and some data cleaning is needed; some wards listed here are in effect the same (i.e. Vascular Ward and Ward 3B).

### Appraisals

Performance Appraisal and Development Review (PADR) compliance has improved, excluding COVID-19, over the 20 months prior to the review but is below target (85%). In January 2019 the rate was 32.61% rising to 64.14% in February 2020 and 79.20% in August 2020.

The figures for appraisals vary with 54 teams (by cost code) reporting compliance below 70% including:

- 050 C E.D Clinic – 0.0%
- 050 C Central Acute Management – 0.0%
- Liver Disease Delivery Plan – 0.0%
- YGC Vascular – 0.0%
- Endoscopy Admin Support – 0.0%
- Ward Clerks Medicine – 0.0%
- Renal & Diabetics Outpatients – 0.0%



- Renal Transplant Nurse – 0.0%
- Reserch AC Unit C.OF E. – 0.0%
- Maxillo Facial Administration – 0.0%
- Orthodontic Administration – 0.0%
- YGC Centre Max Fax Lab – 0.0%
- Medical - Orthopaedics – 0.0%
- ENT Nurse Practitioner – 0.0%
- YGC Ward 3A (was Ward2A) – 0.0%
- Ophthalmics Administration – 2.6%
- E.C.G. – 4.2%
- Surgical Management Admin – 7.7%
- Ward Clerks EQ – 11.1%
- Renal Home Therapies & PD (inc. Anaemia) – 20.0%
- YGC Stoma Care Nurse – 20.0%
- Urology Administration – 22.2%
- GP Out of Hours – 24.5%
- General Surgery Administration – 27.6%
- ED Administration – 33.3%
- Orthopaedic Administration – 40.5%
- Medicine Admin Support – 40.9%
- Medicine Divisional Manager – 42.9%
- YGC Outpatients – 43.3%
- Cardiac Specialist Nurses – 44.4%
- ED Advanced Nurse Practitioners – 50.0%
- CCU Escalated Beds – 50.0%
- Clinical Governance Team – 50.0%
- Coronary Care Unit (C888) 50.0%
- Bowel Screening Wales – 50.0%
- CKD Specialist Nurses – 50.0%
- Orthoptists – 50.0%
- YGC Critical Care Acute Intervention Team – 50.0%
- Tracheostomy Nurse – 50.0%
- Urology Oncology Nurse – 50.0%
- YGC SC Advanced Nurse Practitioners – 50.0%
- Hospital Director – 52.0%
- YGC Major Theatre – 56.9%
- YGC Ward 1 COTE – 58.6%
- Stroke Unit YGC Ward 14 – 59.4%
- Lung Funtion Unit – 60.0%
- Orthopaedics Waiting List Breach Patients – 60.0%
- YGC Ward 19 COTE – 62.1%
- Ward 3 CAU/MFD – 62.5%
- Upper GI MacMillan Nurse – 66.7%
- ENT Administration – 66.7%
- YGC Orthodontic Opd – 66.7%
- Day of Surgical Arrivals – 66.7%

- YGC Ward 4 Cardiology – 69.2%

As these are percentage based figures the figures may be disproportionately affected by small numbers of staff within these teams.

There are some clear “hot spot” areas with poor performing workforce indicators such as vascular, ward 4, etc. The above data is taken from ESR and some data cleaning is needed; some wards listed here are in effect the same (i.e. Vascular Ward, Ward 3A, and Ward 3B).

Medical appraisal is at 99.68%.

It is important to note that the service in factual accuracy checking have reported higher levels of compliance than the ESR data provided to the review (i.e. Central Acute Management at 100%, Endoscopy Admin at 85.71%, Ward Clerks Medicine at 93.75%, Maxillo Facial at 77.78%, Orthodontic Admin at 50%, Ophthalmic at 79.49%, Surgical Management Admin at 46.15%, Ward Clerks EQ at 90.91%, Urology Admin at 90.91%, General Surgery Admin at 95.83%, ED Admin at 100%, Orthopaedic Admin at 88.57%, Medicine Admin Support at 80.95%, Medicine Divisional Manager at 71.43%, and Hospital Director at 54.55%).

### Staff Engagement

The latest staff survey (at the time of writing) had 58 responses from 676 invited staff, a response rate of 8.58%.

The survey showed average “moderately” scores for most areas. The areas of better performance compared to others includes: I am trusted to do my job, I always know what my responsibilities are, The people I work with cooperate to get the job done., I have clear planned goals and objectives. The areas of lower performance includes: The organisation act on staff feedback, Decisions about people are made using fair procedures, Overall the organisation is fair in the way it treats staff, I feel satisfied the organisation values my work, I feel confident in the future of the organisation.

The site report plans in place to introduce a Workforce Partnership Forum to ensure regular dialogue with trade union partners.

## FINDINGS: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

**The service rated themselves for this domain as: Good Practice.**

### Quality Governance

A review was undertaken of the site's quality governance meetings. The meetings use the Health Board's "Issues of Significance" template for directorates to report into the Site Quality, Safety & Patient Experience Committee. This template does not allow effective information and assurances to be reported upwards. For example, one report from the Emergency Care Directorate reports a significant risk for escalation of "ambulance handovers" and another as "WRP issue" with no extra supporting text at all in relation to impact on patients or progress of any improvement work. The meeting includes reports from other divisions such as Area, Cancer, Children's, Women's, MHL D etc and this may cause confusion against its primary purpose of overseeing and managing quality on the site (given the majority of agenda items relate to matters outside of the site). Whilst integrated health economy working is an essential part of an integrated health board's business, the scope of the meeting appears to result in a lack of grip for the site's core business. Attendance is poor; there are regularly absences from key people and the majority of attendees are corporate staff.

As referenced earlier, anecdotal feedback during the review has highlighted the reliance on the Site Governance Team to undertake work that should be led by clinical leaders, and clinical leaders are often operationally focused. Consideration should be given to the roles and responsibilities of leaders across the site to ensure clarity and to ensure that the site is clinically led and operationally delivered.

### Risk Management

A risk management assessment completed by the Corporate Risk Team identified the service as Requires Improvement. The assessment identified 125 risks on the service risk register, of which 84% were reviewed in date. Of a sample (20), 50% were not filled in fully. It appears this review focused on all risks in "Central" and therefore included risks associated with other divisions such as Area and Women's. A more focused consideration by the review team found 57 risks open on the site risk register, of which 10 are scored 15 or higher. These risks include:

- Sterile Services track and traceability
- Lack of consistent pre-operative anaesthetic assessment for Glan Clwyd Hospital vascular inpatients
- Junior doctor cover for the vascular service in hours
- Inadequate heating during winter period
- Delays in patient Glaucoma treatment
- Vascular outliers impacting on inpatient beds in YGC
- Reduced critical care capacity (nurse staffing)
- Follow up waiting lists (FUWL)
- Crowding in the ED
- Delays in patient IVT treatment

A number the risks are several years old with three dating to 2011. A number are overdue their review date, in some cases by considerable time.

### Information Governance

Due to resource constraints and COVID-19 restrictions, no on-site audits have taken place of the service since April 2019, this involved an on-site compliance audit in the discharge lounge due to an allegation of a breach of confidentiality. No further actions were identified and good practice was noted. Work will now commence to obtain confirmation of completion for all previous audits to maintain compliance with the Data Protection Act.

### Ward Accreditation

18 wards have undertaken a ward accreditation visit, with 19 wards to be completed. Of the 18, 39% (n=7) are rated as Silver, 50% (n=9) as Bronze and 11% (n=2) as White. Area still awaiting visits are ITU and Theatres, which have only recently been added to the process and have been delayed due to COVID-19 restrictions which saw a suspension of the programme during spring and summer. The most recent ward accreditation visit to ED in October 2020 identified areas of concern:

- Maintain improvements and staff knowledge / understanding of the SHINE document.
- Network with EDs across BCUHB to share success of SHINE documentation completion.
- Sustain and continue to declutter areas throughout the Dept.
- Declutter and standardisation of resources in each assessment room cupboard.
- Ensure all resuscitation equipment checks are maintained in line with BCUHB standards.
- Ensure redecoration plan developed and implemented.
- Ensure staff adhere to Infection Prevention standards for donning and doffing of PPE.

The re-visit of the ED completed shortly after immediate improvements had been made was positive and demonstrated rapid improvement had been made.

### Regulatory

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. The site has been inspected as follows:

- December 2020 – Follow up remote evidence review of the Emergency Department Inspection 2018;
- August 2020 – Remoter Quality Check inspection of Ward 11;
- July 2019 – Inspection of Trauma & Orthopaedics;
- September 2018 – Follow up inspection of the Emergency Department (original February 2017).

Actions are reported as complete except for Trauma & Orthopaedics; there are 6 actions which remain overdue although 5 of these are for action at a Secondary Care level. These have been ongoing for some time and the site report there have been delays mainly due to COVID-19.

## CONCLUSION

The Quality Governance Review process is designed to provide the service with an honest and supportive assessment of its arrangements and outcomes in relation to the governance of quality (covering patient safety, patient and carer experience, and clinical effectiveness). The primary aim is to drive improvement and to facilitate the sharing of best practice. A secondary purpose is to provide the Health Board with assurance on quality governance within the service, complementing other internal arrangements (such as clinical audit, ward accreditation) and independent or external arrangements (such as internal audit, Healthcare Inspectorate Wales inspections). It is recognised that a new Site Acute Care Director has been appointed, and a new interim Site Nurse Director is in post. This report is therefore presented to support them.

This review is the first of its kind in the Health Board. No similar approach or framework has been identified in Wales. It is therefore acknowledged the framework and methodology will develop over time.

As a result of the pandemic, a significantly reduced methodology was used. For example, on site visits and discussions did not take place and deadlines were extended to allow the site to focus on front line care delivery.

Overall, the site is clearly a very busy and active hospital. While this report focuses on areas of concern, there is clearly dedicated staff working hard to deliver high quality care to patients and good practice to be highlighted and shared. This reflected in the overall positive feedback reported by patients, carers and visitors. However, the areas of concern highlighted in this report are significant and without doubt impact upon the safety of patients, their experience and the effectiveness of the care and treatment they receive. These concerns can be grouped into two areas:

1. Management control and governance – There is an evident challenge experienced by senior leaders in having effective oversight and control of the site. Examples include the historical poor position for incidents and complaints performance, the inability to provide evidence of learning against a historical claim resulting in a suspension of reimbursement, the failure to effectively report serious incidents, a number of infection control issues across different services, etc. This appears to be underpinned by a governance structure that is not effective and clinical leaders who are operationally focused.
2. Sustainable improvements – There is a clear and evident lack of sustainable improvement in key areas such as against key national performance measures. These measures directly relate to quality – the safety of patients, their experience and the effectiveness of healthcare services. Although COVID-19 has significantly impacted this, improvement was not being seen prior and this raises a concern that issues may have become normalised. Using just one measure as an example, 718 people waited for over 12 hours in October 2020 (759 in February 2020 before COVID-19) in the Emergency Department before admission, treatment or discharge. A year and a half earlier this was 673. The Royal College of Emergency Medicine state that lengthy stays in ED departments are associated with increased mortality and poor dignity and privacy for patients.

A number of recommendations (n=12) have been made to support the site with improvement. Many of these actions require support from the Health Board. In particular, the most significant recommendations include the development of an improvement plan, engagement plan, workforce

plan, alongside a review of governance and risk management arrangements. It is the strong view of this review that piecemeal actions are not appropriate and a long term improvement plan is needed for the site to make the necessary changes in a sustainable way. The success of this plan will require the contribution and support of the wider Health Board.

Due to the limitations referenced in this report two key areas have not been able to be explored sufficiently to provide assurance or recommendations – these include the site's learning culture (covering how lessons are identified, learned and translated into sustainable improvements) and the improvement culture (covering quality improvement capacity, capability and utilisation). There is significant corporate work underway to make improvements in these areas and the site should remain actively involved in those.

It should be noted that the review process encountered numerous difficulties in collecting and collating information - different systems, all coded differently, with data quality concerns and with varying levels of access and responsiveness. There is no doubt that leaders at the site also experience these very same issues in trying to obtain, analyse and triangulate information to inform their current position and improvements. The Health Board's overall information strategy should consider this feedback and work towards making triangulated and accurate information easier to access for local leaders and staff.

Due to the issues identified and the need to provide robust assurance to the Health Board, a re-visit is recommended in 12 months to report on progress.

The Review Panel extends its gratitude and appreciation to the leaders and staff at Ysbyty Glan Clwyd who have engaged with this review, and to the corporate teams who have provided data and analysis in support of the review. This appreciation is even more so due to the unprecedented impact on services from the COVID-19 pandemic and the hard work and dedicated of staff across the service to prepare and respond to the challenges. It is recognised that the pandemic will have impacted upon the service and its staff.

## RECOMMENDATIONS

Recognising the current pandemic and its impact on clinical and operational pressures, and the necessary limitations placed upon this review arising from the pandemic, a small number of recommendations have been produced to provide the site with a manageable number of high impact areas for focus.

Following the Quality Governance Review, the following recommendations are made to the service:

1. The site HMT must define clear areas of accountability and responsibility for all Clinical and Operational leads linked to the Health Board's PADR and job planning processes, ensuring there is a clear improvement focus around governance and learning from patient safety incidents and experiences in a timely and effective manner.
2. The site must ensure that there is consistent and appropriate representation at all key operational and governance meetings within the HB e.g. safeguarding. This will be monitored via attendance records, minutes etc.
3. The site must ensure an effective clinical audit programme is in place which is risk-based, in particular ensuring surgical safety is assured.
4. The site must ensure there is an effective audit of clinical and safeguarding documentation with a focus on improvement. This will be monitored via the audit programme, returns and evidenced via the governance framework.
5. The site must ensure that the Local Infection Prevention Group has the appropriate and consistent membership and receives assurance data and has a clear plan regards HCAI prevention / improvement. This will monitored via the LIPG and IPSP submissions and improvement trajectories.
6. The site must ensure there is a sustainable improvement plan developed for areas that demonstrate repeated poor performance identified through the Medication Safety Audit with the appropriate support from Pharmacy and Corporate quality governance teams. This will be monitored via performance and improvement trajectories.
7. The site must ensure there is a robust and auditable process regards the implementation of NICE guidance ensuring there is clear evidence of monitoring of and escalation where there is deviation from the agreed standards. This will be monitored via the clinical effectiveness framework.
8. The site must ensure the Health Board process for Mortality Reviews is in place, that it is monitored and there is evidence of learning and improvement actions in place and assurance is provided via the Health Board governance routes. This will be monitored via the Reducing Avoidable Mortality Review Group.
9. The site must co-produce with patients, staff and stakeholders a sustainable quality improvement plan focussed on improving the key quality underperformance across urgent and emergency care metrics.

10. The site must align its workforce plans with those of the strategic Health Board intent to provide a sustainable recruitment and retention plan, targeting key hotspot areas in the first instance.
11. The site must focus on its profile and engagement both internally and externally with staff, patients and the wider community, positioning itself as the local employer of choice.
12. The site must align its governance structure to that of the overarching Health Board, with a focus on timely intervention and escalation of key areas or issues of concern.
13. The site must address underperformance in areas such as complaints and incident compliance. The site must also ensure that assurance is obtained that lessons learned from complaints and incidents are embedded and sustained.
14. The site must review all Risk Registers ensuring that the registers reflect key issues and are reviewed and updated in line with Health Board policy. The HMT will be versed on all key risks and issues, cited on controls and gaps in assurance which are then escalated deescalated as necessary.

Due to the limitations referenced in this report two key areas have not been able to be explored sufficiently to provide assurance or recommendations – these include the site's learning culture (covering how lessons are identified, learned and translated into sustainable improvements) and the improvement culture (covering quality improvement capacity, capability and utilisation). There is significant corporate work underway to make improvements in these areas and the site should remain actively involved in both.

A re-visit is recommended in 12 months of this report to provide assurance that changes are underway, are making an impact and that sustainability is planned.

The service will be required to complete an improvement plan in response to the above findings. Actions within the improvement plan will be monitored by the Corporate Quality Assurance Team and reported to the PSQ Group in the Quality Assurance Report, with onwards reporting to the Quality, Safety and Experience Committee.





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University Health Board

<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	Quality, Safety and Experience Committee 4 <sup>th</sup> May 2021						
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public						
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	Healthcare Inspectorate Wales (HIW) Update						
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Matthew Joyes, Acting Associate Director of Quality Assurance Julie Ward Jones, Head of Quality Assurance						
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO Matthew Joyes, Acting Associate Director of Quality Assurance						
<b>Atodiadau</b> <b>Appendices:</b>	None						
<b>Argymhelliad / Recommendation:</b>							
The Quality, Safety and Experience Committee is asked to receive this report for assurance.							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>	✓	<b>Er gwybodaeth For Information</b>	
<b>Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol</b> <b>Y/N to indicate whether the Equality/SED duty is applicable</b>						N	
<b>Sefyllfa / Situation:</b>							
Due to the COVID-19 pandemic and the need to prioritise essential functions, reporting into the Committee has been impacted. This paper provides an overview of all HIW activity in the previous year so the Committee is fully sighted in inspections and outcomes. Future more structured reporting on HIW activity is being considered as part of the governance review underway.							
<b>Cefndir / Background:</b>							
HIW inspects the NHS in Wales, from general practices to hospitals. HIW assesses compliance against the Health and Care Standards 2015, the Independent Health Care (Wales) Regulations 2011, and National Minimum Standards (NMS) for Independent Health Care Services in Wales. They also have a specific responsibility to ensure that vulnerable people receive good care in mental health services. As such, HIW also inspect mental health and learning disability settings and considers compliance with legislation. HIW are also requested by HM Inspectors of Prisons to provide a clinical review of a prisoner's healthcare if they die in custody.							
The Health Board manages correspondence and inspections from HIW via an internal standard operating procedure. This procedure has recently undergone a review through a series of workshops with governance leads (January 2021) and is under revision by the Quality Assurance Team with a final version expected to be approved during May 2021.							

The Associate Director of Quality Assurance and their team have enhanced the Datix® PALS module to strengthen the capture and reporting of HIW activity; initially this has been limited to improvement plan actions but has since been expanded to act as a case management system i.e. from initial correspondence through to closure. Discussions have been held with the national Once for Wales Concerns Management System (OfWCMS) project team to include this in the forthcoming RLDatix® implementation, and is included in their list of enhancements which will be prioritised by the national Incident Reporting & Management functionality work stream.

This new database means all HIW activity is logged and recording in one system rather than multiple spreadsheets. It also means that the evidence against the improvement actions is uploaded and monitored through the system rather than locally. Ongoing audits will assure the quality of evidence submitted.

It is important to note that during the first and second wave of COVID-19, HIW suspended all but urgent activity to support the NHS response.

### Asesiad / Assessment & Analysis

In the period April 2020 – March 2021 the inspections covered the following areas:

<b>Mental Health &amp; Learning Disabilities</b> Heddfan Unit, YG: focussed inspection Hergest Unit, WMH: Tier 1 Quality Check Carreg Fawr Unit, Bryn Y Neuadd, Tier 1 Quality Check Ablett Unit, YGC, Tier 1 Quality Check Coed Celyn Hospital, Tier 1 Quality Check	5
<b>Acute Hospital</b> Ward11, YGC, Tier 1 Quality Check ED, WMH, Tier 1 Quality Check follow up ED, YG, follow up Quality Check ED, YGC, follow up Quality Check Bonney Ward, Tier 1 Quality Check Moelwyn Ward, YG, Tier 1 Quality Check	6
<b>Independent GP Practice</b> Ty Grosvenor, Mental Health Independent Hospital July 2020 (Brenig Ward) & October 2020, unannounced focussed inspections The Stables Medical Centre, Flintshire, Tier 1 Quality check follow up	3
<b>Independent Dental Practice</b> Grosvenor Dental Surgery, Colwyn Bay	1
<b>Managed GP Practice</b> Porthmadog Health Centre, Tier 1 Quality Check follow up	1
<b>IRMER</b> – remote compliance inspection North Wales Cancer Treatment Centre	1
<b>Field Hospital</b> – Ysbyty Enfys, Deeside, Tier 1 Quality Check	1
<b>Mass Vaccination Centres</b> Bangor and Deeside, focussed unannounced inspection	1

Of those areas, 4 were follow-up inspections.

Due to the COVID-19 pandemic, HIW considered their approach and adapted their work programme to address this. A key feature of this approach is the use of a three-tiered model of

assurance and inspection that reduces the reliance on onsite inspection activity as the primary method of gaining assurance:

- **Tier 1** - activity will be conducted entirely offsite and will be used for a number of purposes but, at this stage, primarily where issues cannot be resolved via their standard concerns process and where the risk of conducting an onsite inspection remains high.
- **Tier 2** will introduce a combination of offsite and limited onsite activity, whilst
- **Tier 3** will represent a more traditional onsite inspection.

As would be expected the majority of inspections in the period April 2020- March 2021 were carried out off-site by a process identified as a 'Tier 1 – Quality Check'. This process included the completion of a self-assessment form and a call (preferably video-call) with the local manager/lead of the area under inspection. The new approach seeks assurance around four key areas of service. These are arrangements for dealing with COVID-19, environment, infection prevention and control (IPC), and governance.

In November 2020, the Health Board was also informed that the nature of follow ups for Emergency Departments/Unscheduled Care would also change. There would be no video call but a review of the original improvement plan and one self-assessment question on Infection Prevention and Control in the light of COVID-19. This is to make the inspections/follow ups more functional and achievable for all.

### **Summary of inspections April 2020-March 2021**

#### **Heddfan Psychiatric Unit, Wrexham Maelor Hospital, July 2020**

HIW completed an unannounced focussed inspection of Heddfan Psychiatric Unit on the evening of 7 July and the following days of 8 and 9 July 2020. This was in response to staff concerns. The following sites and wards were visited during this inspection: Gwanwyn - Older Persons Mental Health, and Hydref - Older Persons Mental Health.

The inspection found a dedicated staff team that were committed to providing a high standard of care to patients. There was evidence of strong and supportive leadership on both wards. HIW found the service provided safe and effective care. However the Health Board must ensure staff are suitably skilled and trained to care for the ward's specific patient group.

Improvement was recommended for areas of the environment to improve patient safety, communication and involvement with staff around potential strategic changes in the unit, and recruitment into vacant posts.

#### **Carreg Fawr Unit, Bryn Y Neuadd Hospital, September 2020**

Carreg Fawr Unit is an eight bedded mental health rehabilitation unit. The inspection identified a number of positive areas with the key are for improvement as governance and review of policies with two actions to be completed. The actions in relation to this are still outstanding.

#### **Ablett Unit, Ysbyty Glan Clwyd, November 2020**

HIW undertook a Tier 1 Quality Check (remote) of the mental health unit in November 2020. The inspection noted that a number of key specific Infection Prevention & Control (IPC) policies were

unavailable to staff resulting in the Executive Nurse Director writing to HIW to provide assurance that action will be taken to both review and communicate the availability of these policies.

### **Hergest Unit, Mental Health Unit, Ysbyty Gwynedd, March 2021**

The inspection has been completed but we are currently awaiting the draft findings report to review.

### **Coed Celyn Hospital, Wrexham, March 2021**

Coed Celyn is a rehabilitation unit for adults who experience mental health problems. The final report has yet to be published but the draft findings report highlighted a number of positive practices whereby the staff were delivering safe and effective care. There was one improvement noted: for an IPC audit to be undertaken – the date for this is scheduled in April 2021.

### **Ward 11, Ysbyty Glan Clwyd, August 2020**

HIW undertook a remote quality check of Ward 11, Ysbyty Glan Clwyd in August 2020. Ward 11, at that time, was a 24 bed respiratory ward which was caring for designated patients with COVID-19.

Due to evidence received and a call with the ward staff, HIW wrote to the Health Board indicating that they were not assured that appropriate actions had been taken in relation to infection prevention and control audits and that they could not be assured that patient safety was maintained in relation to the management of infection prevention and control. This resulted in the request for an immediate assurance plan, subsequently followed by an improvement plan – both submitted and accepted by HIW.

### **Bonney (Cohort) ward, Wrexham Maelor Hospital, September 2020**

This remote Tier 1 Quality Check focussed on the COVID-19 arrangements in place and included the environment, Infection Prevention and Control, Governance arrangements. The inspection did not identify any areas that required action and improvement.

### **Moelwyn Ward, Ysbyty Gwynedd, August 2020**

Moelwyn Ward, was inspected as a respiratory ward with a high level acuity of patients; some patients would be on Non Invasive Ventilation (NIV) or night time positive continuous airway pressure (CPAP). In response to the COVID-19 pandemic the ward had an aerosol generating procedure bay for patients requiring these.

The inspection identified a small number of improvements required in relation to COVID-19 environmental risk assessment, infection prevention and control practices for the care and maintenance of peripheral cannulas i.e. care bundles and the review and updating of key IPC policies.

### **Emergency Department, Wrexham Maelor Hospital, November 2020**

HIW last carried out an inspection of the Emergency Department at Wrexham Maelor Hospital on 06 and 07 August 2019. The purpose of this follow-up quality check was to check progress on

the recommendations in the improvement plan issued as a result of concerns HIW had at the previous follow-up inspection.

The follow up check resulted in an improvement plan which outlined actions required in relation to patient information, timely access, managing risk and promoting health and safety, medicines management, and infection prevention and control. This has been accepted by HIW.

#### **Emergency Department, Ysbyty Gwynedd, November 2020**

HIW requested a progress update on the improvement plan initially provided following the original inspection in June 2019, as well as requesting information in relation to IPC measures given the current pandemic. The updated improvement plan was submitted in December 2020 with additional comments made in April 2021 with regard to the GP Out of Hours consultation and the business case for increasing staff to support flow and demand during peak periods.

#### **Emergency Department, Ysbyty Glan Clwyd, December 2020**

The follow up quality check was requested in December 2020, following an initial inspection on the 5<sup>th</sup> June 2018. The Health Board has since received a closure letter from HIW confirming their satisfaction with the updates provided.

#### **IR(ME)R Compliance Inspection of North Wales Cancer Treatment Centre, Ysbyty Glan Clwyd - March 2021**

HIW is responsible for monitoring service compliance with the Ionising Radiation (Medical Exposure) Regulations 2017. The Health Board has received positive verbal feedback but is yet to receive any formal findings report.

#### **Ysbyty Enfys, Field Hospital, Deeside, February 2021**

This urgent Tier 1 Quality Check was in response to intelligence received by HIW and the need to receive timely assurance that patients were receiving safe and effective care.

The inspection found committed staff who aimed to provide kind and compassionate care for patients but were not immediately assured that patients were consistently receiving a suitable standard of timely, safe and effective care. Immediate assurance was sought in relation to appropriate care pathways to support individualised care, documentation of discussions relating to end of life care, review of Infection, Prevention and Control requirements in the models of care provided and record keeping and documentation in all areas. The Health Board responded and provided evidence to support immediate actions which has since resulted in HIW finding sufficient assurance that actions have been taken in response to the issues outlined.

#### **Mass Vaccination Centres, Bangor and Deeside, March 2021**

In January 2021, HIW wrote to the Health Board informing us of their plans to seek assurance on the quality, safety and effectiveness of the arrangements in place when delivering the COVID-19 vaccination strategy. This included eight focussed inspections of Mass Vaccination Centres (MVC) across Wales. Two of these included the MVC's at Bangor and Deeside.

The Health Board recently received the draft findings and improvement plan which highlights such areas as the monitoring of waiting times and communication across the MVC's with regards to staff rotas.

### **Porthmadog Health Centre, Gwynedd, March 2021**

HIW undertook an inspection of the practice on the 9<sup>th</sup> October 2018; since the 1 October 2018, it has been under the management of the health board. Whilst the findings report has yet to be published, the draft report found evidence that the service provided a positive experience, and safe and effective care to patients. HIW found that the service had implemented and sustained the improvements highlighted in the original inspection improvement plan and there were no follow up actions to be undertaken.

### **Ty Grosvenor, Independent Hospital Provider of Mental Health services, Wrexham, July and October 2020**

Whilst the Health Board is not involved in inspection of the Independent Provider we are informed of the published findings report. The issues raised in the report related to the failure of an effective audit and governance framework.

### **Grosvenor Dental Practice, Private Practice, Colwyn Bay, September 2020**

Whilst the Health Board is not involved in inspection of the Independent Provider we are informed of the published findings report. The inspection found evidence that the practice was not fully compliant with all standards and regulations and put an improvement plan in place.

### **The Stables Medical Practice, Flintshire, September 2020**

Following the inspection at this medical practice, immediate assurance was requested to support improved staff training, audit and governance.

### **Themes**

It is important to note that due to the nature of the questions asked during the amended inspection format, many of the actions or improvements arising relate to IPC. The one challenge found during the self-assessment process is the visibility and availability of up to date IPC specific policies. The Executive Director of Nursing and Midwifery directed urgent work to address this.

### **Conclusion**

The HIW inspection process provides the Health Board with significant opportunities for learning, from both the improvement plans and the positive practices and experiences described in the findings reports.

As previously described a way to track, and potentially identify any themes from the actions, is to use the concerns management system known throughout the Health Board as Datix®. The use of this system for HIW is relatively new, with the actions placed on the system following transfer from the previous 'tracker' spreadsheets. The plan is that this will mature in time to provide a whole system view of HIW activity and to enable triangulation with other aspects of improvement planning and action setting e.g. complaints, incidents and claims.

An overview of the outstanding actions is as follows:

Speciality	Overdue	Update
Adult Community Mental Health Services	1	Review and update of ligature risk assessments – presented to service PTR meeting 28/04/2021, then as an agenda item on H&S and QSE in early May – then closed
Older Persons Mental Health Services (WMH)	1	Following an initial recruitment advert which failed to attract any applicants, the ANP post has is currently going through the recruitment process again. In the interim mitigation is in place by joint meetings with Area teams to work on improving the physical health to the patient population of Heddfan – closure to be reviewed when and if the ANP is recruited otherwise action revision will be undertaken
Emergency Department (Secondary - WMH)	1	The action in relation to the communication of waiting times and managing patient flow through the department is partially complete i.e. an audio announcement system is in place that makes general announcements to the waiting area and also allows us to update the system with expected waiting time to see a clinician. Recruitment of additional medical staff as well as working with the wider hospital team to improve flow is part of part of larger action plan which is being worked on over the coming 6 months.
Mental Health and Learning Disabilities (BYN)	2	Bed escalation policy due to be ratified at the Policy group meeting scheduled for 29/04/2021 – this will then be closed  Policy Group to be re-instated April 2021 – this will then be closed
Respiratory Medicine (Secondary - YG)	1	Assurance required that an action plan is in place to address the low compliance with the PVC bundle.
Trauma/Orthopaedics (Secondary - YGC)	2	Both actions relate to elective inpatient activity in Abergele hospital which has been suspended during COVID.
Childrens (including CAMHs) – thematic review	4	Some specialties within C&YP services have robust transition protocols in place. A general transition policy for C&YP services will be developed to ensure best practice across all services – there has been some delay due to COVID but a revised due date is being considered (x 2 actions)

		<p>All under 18yr breaches are reviewed, the cause of the breach identified and the relevant speciality is informed for further local review and action. At times when ED is in high escalation and waiting times are likely to be long, direct streaming to specialty/age appropriate bed is in operation. Discussions being held as to what further actions can be undertaken</p> <p>CAMHS bed availability meeting monitors bed availability and those in age appropriate beds nationally. Pathway for use of age appropriate bed is in draft awaiting approval</p>	
	Grand Total	12	

Future work of the Quality Assurance Team is to provide a better insight into this information to enable the triangulation of assurance data resulting in more robust information to identify areas for improvement, as well as support better action tracking (via Datix and not a spreadsheet tracker).

**Goblygiadau Strategol / Strategy Implications** – Not applicable.

**Opsiynau a ystyriwyd / Options considered** - Not applicable.

**Goblygiadau Ariannol / Financial Implications** – Not applicable.

**Dadansoddiad Risk / Risk Analysis** – This is contained within the report.

**Cyfreithiol a Chydymffurfiaeth / Legal and Compliance** – This is contained within the report.

**Asesiad Effaith / Impact Assessment** – Impact assessments are not required for this report





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University Health Board

<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	Quality, Safety and Experience Committee 4 <sup>th</sup> May 2021						
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public						
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	Healthcare Inspectorate Wales (HIW) Maternity Review : BCU Action Plan						
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Erika Dennis, Senior Quality Assurance Manager						
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CE Matthew Joyes, Acting Associate Director of Quality Assurance						
<b>Atodiadau</b> <b>Appendices:</b>	HIW Maternity Review Action Plan						
<b>Argymhellid / Recommendation:</b>							
The Quality, Safety and Experience Committee is asked to receive this report for assurance.							
<b>Ar gyfer penderfyniad /cymeradwyaeth</b> <b>For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth</b> <b>For Discussion</b>		<b>Ar gyfer sicrwydd</b> <b>For Assurance</b>	✓	<b>Er gwybodaeth</b> <b>For Information</b>	
<b>Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol</b> <b>Y/N to indicate whether the Equality/SED duty is applicable</b>						N	
<b>Sefyllfa / Situation:</b>							
This paper provides the Committee with an update on the Action Plan developed in response to the HIW National Maternity Review (published in November 2020). The action plan was approved at the Patient Safety and Quality Group in February 2021, with an update (Appendix) received at the April 2021 meeting. The plan is being provided for assurance.							
<b>Cefndir / Background:</b>							
HIW launched the national review of maternity services across Wales in June 2019. Phase one of the review ran from June 2019 to summer 2020. The national review explored the experiences of women, their partners and families, and the extent to which Health Boards across Wales:							
<ul style="list-style-type: none"> <li>• Provided safe and effective maternity services</li> <li>• Understood the strengths and areas for improvement within their maternity services.</li> </ul>							
From June 2019 to January 2020 HIW carried out a programme of unannounced inspections of maternity services across Wales. Following this, they carried out a further programme of announced inspections within free standing birthing units. Each inspection resulted in its own inspection report.							

All maternity inspection reports and the terms of reference for Phase One have previously been reported to QSE and can be found on HIW's website <https://hiw.org.uk/>.

HIW are now working on phase two of the review and it is their intention to conduct phase two of the national review during March 2021, with a view to reporting their findings by summer 2021. HIW are aware that these timescales may be contingent upon the impact of the COVID-19 pandemic, and winter pressures.

Phase two will conclude with an overall national review report, which will incorporate phase two findings and will reflect on phase one, and the overall review conclusions. It seeks to report in more detail on antenatal and postnatal care, and follow-up on some inspections undertaken phase one.

### **Asesiad / Assessment & Analysis**

HIW expected all Health Boards across Wales to carefully consider the findings from the phase one review and the recommendations set out to further improve services being provided to women, and to inform further work across Wales. The findings within the review so far have enabled HIW to review the scope and direction of phase two.

Each Health Board and Welsh Government were required to submit an improvement plan in response to the recommendations. This is to ensure that the matters raised by the review are being addressed.

Discussions with Welsh Government and HIW took place at a briefing event in November 2020, and it was specifically agreed that health boards have a three months response and return time scale as there are to some national actions to support the overall response.

In response to the report the following steps were in place:

#### **Locally**

- 1) Formally reviewed the phase one report and discussed the findings and learning at the Women's Service Board on 27th November 2020.
- 2) Considered all 32 recommendation for Health Boards and the 5 recommendations for Welsh Government's consideration.
- 3) The full report was circulated by e-mail to all staff within the Women's Directorate.
- 4) The slides from the WG/HIW Learning Event have been circulated to Leads / Managers to inform local discussions as part of the Women's governance structure.
- 5) An update on the findings of the Report and the Service's response was presented to executives colleagues at an Executive Accountability meeting on 26/11/20 and a formal update was provided to the Patient Safety and Quality Group on 11/12/20.

#### **Nationally**

- 1) A multidisciplinary team representing local services attended a National Learning Event on the 2 December 2020, hosted by Welsh Government and HIW, in response to the publication of the report.
- 2) The team representing the health board presented their top 3 priorities having reflected on the findings and learning from the report
- 3) The Director of Midwifery and Women's Services attended a meeting of the Heads of Midwifery Advisory Group to consider the recommendations made in the report and

looking at national solutions going forward. The HIW Lead Investigator for this review was present at the meeting.

- 4) The Director of Midwifery and Women's Services also sits on the HIW Maternity Review Stakeholder Group and attended a meeting on 8 December 2020 where; the findings of the phase one review were shared, an update from the National Learning Event was provided, a comprehensive discussion was held regarding the scope of phase two of the review and timing of this phase due to COVID was considered.

The actions are being managed and tracked by Midwifery and Women's Services, and through the HIW tracking database, with reporting to the Patient Safety and Quality Group. The latest update was received at the April 2021 meeting. Attached to this paper is a report including a position update on all actions – 22 of 32 recommendations are reported as complete, 10 are in progress and 1 is not applicable.

**Goblygiadau Strategol / Strategy Implications** – Not applicable.

**Opsiynau a ystyriwyd / Options considered** - Not applicable.

**Goblygiadau Ariannol / Financial Implications** – Not applicable.

**Dadansoddiad Risk / Risk Analysis** – This is contained within the report.

**Cyfreithiol a Chydymffurfiaeth / Legal and Compliance** – This is contained within the report.

**Asesiad Effaith / Impact Assessment** – Impact assessments are not required for this report.



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## BCUHB WOMEN'S DIRECTORATE

### RESPONSE TO HIW RECOMMENDATIONS

### APPENDIX C (NOVEMBER, 2020)

#### COMPLIANCE

32 Recommendations

1 x N/A

10 x Amber

22 x Completed

**72%**

**FIONA GIRAUD – DIRECTOR OF WOMEN'S SERVICES**

# Appendix C – Health Board Recommendations

As a result of the HIW National Maternity Review (November 2020) findings, HIW have identified the following recommendations in the table below. Where applicable, the health boards should:

Recommendation		
1. Ensure that women are aware of how they can request information or support in their language of choice.		
Action	Responsible Officer	Timescale
<p>Women are asked about their language of choice and in which language they wish to receive information at booking. Their choice is then recorded on the All Wales Hand Held Notes for all future visits and contacts and as per the Welsh Language Act (1993).</p> <p>BCUHB have in place a local policy that promotes the Welsh Language Act. In addition, bilingual maternity documentation is available across all services.</p> <p>Should a woman require language assistance, for example an interpreter or other communication support, this can be arranged through the Wales Interpretation and Translation Service (WITS). This meets all types and levels of language needs. Information is also accessible in various formats, to meet sensory needs. Patient leaflets are available to provide the necessary contact information for WITS and is available on the intranet (ISU02).</p> <p>Patient Information Booklets for Maternity Services are also available through a wide range of languages to meet a variety of cultural needs.</p>	Head of Women's Services	Completed

## Recommendation

2. Ensure that wherever possible, women are able to communicate in their language of choice.

### Action

The BCUHB Women's Directorate encourages communication through language of choice by ensuring Welsh speaking staff are available, as identified through their uniforms to help women recognise staff who are Welsh speaking.

Translation Services are available through "Wales Interpretation and Translation Service" (WITS) for all other languages, and support services are also available for women who have hearing or visual impairment.

### Responsible Officer

Head of Women's Services

### Timescale

Completed

## Recommendation

BCUHB Women's Directorate (Updated 29<sup>th</sup> March 2021) Version 2.  
3. Consider how water birth options can be made available across all units.

### Action

Water as an option for birth is available across BCUHB as follows:

### Responsible Officer

Head of Women's

### Timescale

May 2021

<p>A buddy community midwife is also assigned to each woman to provide care if the named community midwife is not available for any unforeseen reason.</p> <p>Audits of community midwifery continuity of care are completed on a monthly basis using the All Wales Hand Held Notes and results demonstrate a rolling compliance above 80%.</p> <p>Midwifery Lead Care is provided in line with NICE guidance 'Antenatal Care for Uncomplicated pregnancies (2019) CG62'.</p>		Completed
<b>Recommendation</b>		
5. Consider the introduction of smoking cessation leads.		
<b>Action</b>	<b>Responsible Officer</b>	<b>Timescale</b>
<p>Betsi Cadwaladr University Health Board has committed to the development of an integrated Help Me Quit (HMQ) Smoking Cessation Service.</p> <p>A HMQ Smoking Cessation Strategic Lead will be in post by early 2021 supported by an operational lead for the Service. These two roles will be responsible for the regional co-ordination and delivery of all HMQ services across North Wales.</p> <p>The operational lead will be responsible for the direct management of the Help Me Quit for Baby Service, which provides support for all pregnant women and their partners throughout pregnancy and for the first month of the post-natal period. This post holder together with the Smoking Cessation Support workers will be responsible for promoting and offering the service to all pregnant smokers. The above plans correlate with MBRRACE UK recommendations and features within BCUHB Women's Directorate Stillbirth Reduction Action Plan.</p> <p>Update: The new HMQ Service Strategic Lead for primary and community care has been appointed which will integrate the 3 teams. This is to ensure that the leadership required is pan BCUHB to ensure that the staff integrated into the one team receive the operational oversight and direction to</p>	BCUHB Primary Care Strategic Lead – East Area	Completed

<p>maximise their potential in terms of their client numbers and outcomes. This would provide the benefits of supporting economies of scale within the service with cross cover provided to the priority areas and across between Health Board areas. This role will be responsible for both operational and strategic requirements of the service. This post would support the data collection and reporting required for the smoking cessation dashboard and in turn, national reporting that is required as part of the service.</p> <p>This is promoted through the BCUHB Women's Directorate 3 Year Strategy, Priority 3, action 6.</p>		
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Recommendation		
6. Consider working with Public Health Wales to further promote healthier living and lifestyles.		
Action	Responsible Officer	Timescale
<p>Local Public Health Team representatives are key members of the BCUHB Women's Service Board and an integral part of maternity operational services. The Executive Director for Public Health is the Women's Directorate Executive Lead.</p> <p>In order to promote healthier living and lifestyles, joint actions for the year 2021/22 have been developed which includes the Bevan Exemplar Project, commenced in Oct 2020, with an initial report due March 2021. The Bevan Exemplar Project, includes work streams as follows:</p> <ul style="list-style-type: none"> <li>Commissioning insight work into 'Healthy Weight in Pregnancy' to inform future recommendations regarding Maternal Obesity and upstream preventative, life course changes. Insight work led by Beaufort Research, underway. Final report to be presented to Women's Board in July 2021.</li> </ul>	<p>Principal Early Years Lead - BCUHB Local Public Health Team</p> <p>Public Health Dietetics in partnership with NS4L National Training Lead</p>	<p>April 2021 – Revised to July 2021 due to COVID pressures.</p>



<ul style="list-style-type: none"> <li>• Continue to ensure Public Health information is available to women and their families for promoting health and well-being, including advice on healthy eating, the dangers of smoking, alcohol and drug use, and vaccinations during pregnancy. BCUHB Local Public Health Team to review and supply required patient information and resources across maternity units (acute and community) and other key contact points for families on six monthly basis.</li> <li>• Providing access to the Solihull Parenting Approach online courses to families across North Wales and continue to promote these resources to increase uptake across the Region. Successfully launched in April 2020 and positive levels of reach since. As at February 2021 a total number of n=3,551 actual learners in North Wales. Solihull Parenting Approach Training also provided to partners across North Wales providing more staff with the evidenced based skills to support Women and Families.</li> <li>• Supporting the Infant Feeding Quality Improvement Programme progressing under the leadership of the NW Infant Feeding Strategic Group. Infant Feeding Support Workers appointed. Quality Improvement Planning underway and EqlA completed and approved by Women's Board – February 2021</li> <li>• Working nationally with Nutrition Skills for Life/Public Health Dietitians in Wales to support development and implementation of the 'Foodwise In Pregnancy' App to support women in eating well, being active and managing a healthy weight gain during pregnancy.</li> <li>• Supporting the seeking to improve the uptake of Healthy Start vitamins amongst Pregnant and Breastfeeding women.</li> </ul>	<p>Leads for Level 2 and 3 weight management service</p> <p>Principal Early Years Lead - BCUHB Local Public Health Team</p>	
<b>Recommendation</b>		
7. Ensure the appropriate level of breastfeeding advice, guidance, and support is provided at all times.		
<b>Action</b>	<b>Responsible Officer</b>	<b>Timescale</b>

<p>As part of the BCUHB Women's Strategy 3 Year Plan, Priority 1 and 3, a BCUHB Infant Feeding Strategic Plan (2019) has been developed, (based on the WG All Wales Breastfeeding Five Year Action Plan). Significant progress has been made to date, that includes an approved revenue business case for breastfeeding support workers, and a North Wales Infant Feeding Strategic Lead. As a result, the following has been promoted during year 2020/2021:</p> <p>Raise levels of Lactation/breastfeeding education, knowledge &amp; skills in midwifery teams. This has been promoted through:</p> <ul style="list-style-type: none"> <li>• The BCUHB Breastfeeding/Lactation Education pathway, exploring investment in additional training and professional development pathways and opportunities for midwives with special interest, as identified by their PADR so that they are able to progress &amp; develop professionally in the field of lactation care.</li> <li>• Increasing membership of the North Wales Infant Feeding special interest group on social media to share research, information &amp; create momentum &amp; interest in the field.</li> <li>• Greater use of virtual consultation by mothers i.e. "Attend Anywhere" access to Infant Feeding Specialist.</li> <li>• Greater use of the Infant Feeding "hub" email facility for midwives to gain rapid access to guidance from the Infant Feeding Team when needed.</li> <li>• Collaboration with Children's services to support development of Breastfeeding/Lactation specialist services in Health visiting &amp; Neonatal services so that the woman's breastfeeding journey is safeguarded across our allied services.</li> <li>• Continue working in partnership with our 3<sup>rd</sup> sector breastfeeding support voluntary service in North Wales.</li> </ul> <p>Specific actions for 2021/22 have been identified which includes:</p> <ul style="list-style-type: none"> <li>• Undertake a pilot project of Infant Feeding Support workers initially, in an inpatient environment (funded from WG Building a Healthier Wales) with full evaluation thereafter, in order to scope out further across North Wales. Commence services in East as from January 2021. Update March 2021: Infant Feeding Support Workers commenced in post in January 2021. (Update provided as above).</li> </ul>	<p>Lead of North Wales Infant Feeding Strategic Group</p> <p>Public Health Wales</p> <p>Head of Women's Services</p>	<p>April 2021</p>
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<ul style="list-style-type: none"> <li>• Recruit to the North Wales Infant Feeding Strategic Lead post (in line with WG All Wales Breastfeeding Five Year Action Plan). Update March 2021: Job Description for IF Strategic Lead Post not available from WG. Enquires made as to when the JD will be available.</li> <li>• Invest in the “entry level” Breastfeeding/Lactation training with 3<sup>rd</sup> sector support for breast feeding support workers.</li> <li>• Re-model services to ensure there is site-specific cover across all units, to ensure improvements in care provision, offer leadership, and promote improvements in standards of care. Update March 2021: part of the QI project.</li> <li>• The Infant Feeding Communications plan continues to be implemented; Breastfeeding booklets have been developed by a virtual group and have been circulated. A range of communications around Breastfeeding and Covid-19 have been developed and uploaded directly onto both staff and public facing web pages.</li> <li>• In collaboration with IF Strategic Group members, a briefing has been drafted to share with stakeholders to provide an update on what has been achieved since the launch the Infant Feeding Strategy in March 2019.</li> </ul>		
<b>Recommendation</b>		
8. Review the adequacy and availability of perinatal and postnatal mental health support for women.		
<b>Action</b>	<b>Responsible Officer</b>	<b>Timescale</b>

<p>The availability of perinatal and postnatal mental health support for women has recently improved due to a recent approved business case that supports the introduction of the following posts into the service, as from 7<sup>th</sup> January 2021:</p> <p>1 x wte Perinatal Nurse Practitioner Band 6  2 x wte Nursery Nurse Band 4  1 x wte Occupational Therapist Band 6  0.5 wte Psychologist  0.5 wte Non-Consultant Psychiatrist</p> <p>The Health Board also has a Named Perinatal Mental Health Obstetric Lead for North Wales.</p> <p>The service is available to all women across North Wales and the structure to ensure availability of support has been confirmed as below.</p> <p>In terms of reviewing the adequacy of support provided, BCUHB Perinatal Mental Health Team has committed to achieving the “Perinatal Quality Network College Centre for Quality Improvement Standards”. A variety of local audit programmes will therefore take place from January 2021, to review compliance and standards by means the Perinatal Mental Health SharePoint, which will determine number of referrals to service; numbers accepted/declined (with reasons).</p> <p>An Audit sample of antenatal handheld notes from each of the three areas will take place to determine missed opportunities for referral to specialist services; alternative support offered for women referred but not meeting criteria for specialist service; evidence of mental health and wellbeing enquiry at each contact with all women. Further improvement work for 2021/22 includes:</p> <ul style="list-style-type: none"> <li>• Implementation of ‘Perinatal Mental Health Champions’ across the multi-disciplinary team; these champions will be individuals who will receive additional training and support and will act as a link between their own teams/services and the specialist team.</li> </ul>	<p>Perinatal Mental Health Service Manager</p> <p>Specialist Perinatal Mental Health Midwife</p> <p>Mental Health Practitioners</p> <p>Perinatal Mental Health Team</p> <p>WHiS</p>	<p>Completed</p>
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- Provision of additional training and clinical supervision sessions to midwives and associated maternity staff to improve knowledge and skills and provide support when involved in caring for women with complex needs. It will also allow staff a space to provide feedback regarding their experiences of working alongside other disciplines.
- Perinatal Mental Health Team to encourage service users and their families to provide confidential feedback, which can be used to further improve and develop the service.
- With consent to share the maternity care experiences of women referred to the Perinatal Mental Health Service with maternity service regularly, within the appropriate forums.

The adequacy and availability of perinatal and postnatal mental health support for women also features on the Women's Directorate monthly accountability meetings, to monitor the levels of support and care plans in place.

**Update March 2021:** 'Perinatal mental health champions' have been identified across BCU in a range of services. The iHV multi-disciplinary training programme is now live. Specialist midwife to provide SBAR for impact of both champion role and iHV training on workforce, to be discussed at SMT and training board. On discharge women and families are signposted to snapsurvey to provide feedback, which is collated by RCPsych. The PNMH team has had its first review as part of the RCPsych CCQI accreditation programme, feedback from which was very positive. Following discussion with Head of Midwifery, agreed specialist midwife to begin audit of All Wales HHN, initially in community midwifery bases, due to covid 19 restrictions to determine missed opportunities, alternative support offered for women not requiring specialist services and level of enquiry re mental health and wellbeing at each contact. To liaise with Dave Farmer to agree timetable for completion.

Finally, The BCUHB Women's 3 Year Strategy, makes clear under priority 3 (action 3), the need to improve multidisciplinary provision, and increase membership of the steering group. The BCUHB maternal mental health pathway is also under review to ensure compliance with NICE Guidelines by April 2021.

Nationally, Welsh Health Improvement Services has agreed to fund two mother and baby beds/placement for resident of North Wales in the North West. Potentially at Clatterbridge or at the Countess of Chester.		
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Recommendation		
9. Consider the introduction of PRAMS across its services.		
Action	Responsible Officer	Timescale
<p>The Women's Directorate is actively working with Early Years Path Finders in Flintshire to explore how the Health Board can introduce PRAMS locally and support family wellbeing, relationships and emotional development in a COVID Recovery Project. Further work is ongoing across Anglesey to establish pathways.</p> <p>Please see attached information leaflet.</p>		<p>April 2021</p> <p> PRAMS A4 leaflet.pdf</p> <p>(subject to COVID pressures)</p>
Recommendation		
10. Ensure that staff are able to access bereavement training in a timely manner.		

Action	Responsible Officer	Timescale
<p>The BCUHB Women's Directorate provides bereavement training to staff in the following ways:</p> <ul style="list-style-type: none"> <li>• A bereavement training update is provided on a twice yearly basis, as sighted on the Midwives' mandatory training schedule and is included in the services' training needs analysis.</li> <li>• Training within clinical areas also takes place and includes therapy such as memory making and offers guidance on how to use the bereavement pathways. Post-mortem consent training is also arranged in conjunction with medical colleagues.</li> <li>• The bereavement midwives also attend a 'train the trainer' session, which is held twice yearly.</li> <li>• It is also planned that all newly qualified staff and staff new to the health board will have a small group session with a bereavement midwife to look at local pathways and guidance within 3 months of commencing in post. This will be implemented from January 2021.</li> <li>• There are bereavement link midwives identified on each site to provide daily support.</li> </ul> <p>We have now successfully recruited to a third Bereavement Midwife to ensure that all sites across North Wales have in place support across each area.</p>	Bereavement Midwives	Completed
Recommendation		
<p>11. Consider what steps can be taken to ensure that learning from women's experiences can be improved, with a particular focus on sharing what has changed in response to feedback.</p>		

Action	Responsible Officer	Timescale
<ol style="list-style-type: none"> <li>1. The Health Board are in the process of introducing/implementing a new process for incidents, complaints, claims, redress, safety alerts and inquests which will focus on learning and improvements with improved use of technology.</li> <li>2. Introduction of the New Datix IQ Cloud System will improve the quality of information and the ability to triangulate data and learning.</li> <li>3. The Health Board are also implementing a new skills and passport for those involved in investigations and sharing of learning.</li> <li>4. Learning from Women's experiences is shared in response to all forms of feedback. For example, the Women's Directorate programme of audit findings are now shared with Maternity Voices groups, which illustrates the co-productive nature for service improvement and learning. This also reflects the recommendations from The National Maternity and Perinatal Audit Organisational Report (2019) which recommends women are involved in audit.</li> <li>5. Furthermore, a quarterly lessons learned themes and trends report has been produced with a focus on women's experiences from various perspectives such as claims, concerns, incidents, Public Service Ombudsman Wales and patient stories. This report/newsletter is shared across the Directorate and with Maternity Voices on a quarterly basis.</li> <li>6. Regular Group Supervision sessions take place, as led by the Clinical Supervisors for Midwives Team, whom include lessons learned from patient stories, incidents and claims with midwives and this offers further opportunities for feedback to all midwives with regards to women's views.</li> <li>7. As part of midwifery mandatory training in 2021, a session on 'Listening to Women' has been developed. Included in this is a summary of national Reports such as Ockenden and HIW phase 1 recommendations, the NMC code with reference to listening etc. During the session, clinical supervisors share anonymised women's stories from BCU and discuss important themes like advocacy, consent, communication. Direct communication and feedback is obtained by talking to women through 'Birth Afterthoughts' and their stories become the basis for these sessions (with their consent). The sessions are concluded by sharing positive feedback from women via the health board directly or via social media streams such as Maternity Voices, Betsi Best etc.</li> </ol>	<ol style="list-style-type: none"> <li>1. Corporate Patient Safety Team</li> <li>2. Corporate Quality Assurance Team</li> <li>3. Corporate Patient Safety Team</li> <li>4. Governance Midwife Lead</li> <li>5. Governance Midwife Lead</li> <li>6. Professional Development Midwife</li> <li>7. Head of Women's Patient Experience Team</li> <li>8. Head of Women's Patient</li> </ol>	<ol style="list-style-type: none"> <li>1. September 2021</li> <li>2. July 2021</li> <li>3. 31 March 2021 revised date due to C19 pressures June 2021</li> <li>4. Completed</li> <li>5. Completed</li> <li>6. Completed</li> <li>7. Completed</li> <li>8. May 2021</li> </ol>



<p>8. BCUHB Patient and Carer Experience Team are working on promoting an online version of patient feedback questionnaire, which will hopefully be launched in spring 2021.</p> <p>Feedback from women also provides the required changes to the Training Needs Analysis for future staff training and development, to ensure continued high standards of care.</p> <p>Furthermore, following recent Organisational Change, the Women's Directorate is in the process of developing a Patient Experience and Development Team that will include clinical supervisors, Professional Development Midwives and Bereavement Midwives. This has been achieved as from 1<sup>st</sup> April 2021. All learning from claims, concerns, incidents, Public Service Ombudsman Wales and patient stories are discussed at the Women's Directorate Quality, Safety &amp; Experience Group on a monthly basis and is then disseminated via local team meetings.</p>	Experience Team	
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## Recommendation

12. Consider strengthening arrangements for sharing patient stories at board and quality and safety committees.

Action	Responsible Officer	Timescale
<p>Patient stories are prepared by the Consultant Midwife and Clinical Supervisors for Midwives, from the experiences shared by women at 'Birth After-thoughts' and 'Maternity Voices'. These accounts are then shared across a range of meetings within the Women's Directorate, such as;</p> <ul style="list-style-type: none"> <li>• Women's Board</li> <li>• Women's Quality, Safety &amp; Experience Sub-group</li> <li>• North Wales Labour Ward Forum and Local Forums</li> <li>• Local Audit and Operational Site meetings</li> </ul>	<p>Head of Midwifery Service</p> <p>Clinical Supervisors of Midwives</p> <p>Governance and Risk Lead</p>	Completed

<ul style="list-style-type: none"> <li>North Wales Audit Conferences</li> </ul> <p>The Consultant Midwife and Clinical Supervisors for Midwives also feedback all positive comments and areas for improvement to named individuals, as agreed by the women providing the story.</p> <p>The Clinical Supervisors for Midwives also provide five stories for interactive discussion for learning purposes on monthly mandatory training sessions for all midwifery staff. The themes of the stories reflect the learning with regards to communication with women and in learning from national reports on maternity services and reviews, are also discussed and reflected upon in these sessions.</p> <p>The BCUHB Corporate Patient Experience Team also provide patient stories following concerns and/or complaints which are cascaded across the Senior Management Team which are then triangulated with Women's Board.</p> <p>A quarterly Newsletter is under development, which will highlight patient stories across the Directorate on a monthly basis, commencing in January 2021.</p> <p>Patient stories (both positive and negative) are also capture on social media and service evaluation forms. This information is shared widely pertaining to each unit or community service for wide learning and professional reflection.</p>		
<b>Recommendation</b>		
13. Ensure the ongoing monitoring in line with health board policy of neonatal resuscitaires and emergency medical equipment.		
<b>Action</b>	<b>Responsible Officer</b>	<b>Timescale</b>

<p>Monitoring neonatal resuscitaires and emergency medical equipment is a key priority for maternity services across BCUHB. As such, robust arrangements and processes are in place to support daily monitoring of equipment that involves assessing the working condition; ensuring items are serviced regularly and testing items to confirm fit for purpose. Raising awareness of responsibility amongst staff and adherence to local policy forms an essential part of the weekly matron's ward round, in addition to supervision, team meetings and monitoring undertaken by management. All of which, ensures processes are in place for monitoring and supporting compliance with Health and Safety legislation.</p> <p>Examples of such processes, includes a daily-designated shift leader, who checks that all resuscitation equipment and medical equipment, located in the respective maternity unit, is completed and documented. This provides an auditable trail of local monitoring, and weekly findings to confirm a compliance rate of 90%.</p> <p>Resuscitation equipment in the Free Standing Midwifery Units (FMU's) is checked at a minimum on a weekly basis and when a midwife arrives on the unnamed unit. This is included in the Standard Operating Procedure (SOP) Governance Arrangements for the Free Standing Midwifery Led Units.</p> <p>All community midwives also have access to a birthing bag, content of which is consistent with the equipment inventory as cited in appendix 4 of the SOP 'Governance Arrangements for the Free Standing Midwifery Led Units' mentioned above. Compliance monitoring of these checks are monitored weekly.</p>	Head of Women's Services	Completed
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## Recommendation

### 14. Ensure staff awareness of procedures and responsibilities to follow in the event of a medical emergency.

Action	Responsible Officer	Timescale
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<p>In the event of a medical emergency, BCUHB Women's Directorate ensures that all clinical staff are aware of their responsibilities and local procedures by reviewing actions taken in an emergency and encouraging reflective practice. Should any incident occur, a 'Make it Safe' process is followed which encourages a root cause analysis around any specific issue and promotes learning across the Directorate. In cases whereby a serious incident review is required, a full investigation will take place, and as part of this process, staff awareness of local procedures and their responsibilities is reviewed as part of their practice / professional reflections.</p> <p>The BCUHB's Women's Directorate has a robust governance and accountability framework in place that monitors specific key performance to relevant emergency care indicators. Thematic reviews also take place whereby improvement in practice is noted. Trends relating to learning informs the Directorate's training needs analysis to ensure learning is applied in practice.</p> <p>Staff mandatory training is also paramount with respect to PROMPT, which details the procedures and responsibilities to follow in the event of a medical emergency. PROMPT algorithms are available as laminated copies in all clinical areas and community PROMPT algorithms are also available for community midwives.</p> <p>In addition to annual mandatory training as per the Women's Directorate Training Needs Analysis, the maternity service is required to undertake regular emergency skills drills to maintain the required competencies for home birth, FMU birth, alongside MLU birth and Obstetric unit births. Planning of the unannounced and on occasions, announced drills is undertaken in conjunction with the Professional Development Midwife to reflect clinical needs of the teams. Responses are monitored to ensure all members of staff feel confident and competent to manage medical emergencies.</p> <p>Activating the emergency bell in the Free Standing Midwifery Led Units is also included in the aforementioned SOP named 'Governance Arrangements for the Free Standing Midwifery Led Units'. All community midwives have a copy of the above and a member of the community midwifery team (with an FMU in their locality) is responsible for activating the emergency bell and maintaining the site responses on a monthly basis. A record of this is maintained, including the assessment of the team's response.</p>	<p>Head of Women's Services</p> <p>Professional Development Lead</p> <p>Community Midwifery Teams</p>	<p>Completed</p>
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## Recommendation

### 15. Ensure staff awareness of procedures and responsibilities to maintain the safety of the women using water birthing facilities.

Action	Responsible Officer	Timescale
<p>Water Birth Facilities are managed in a number of ways, in particular the responsibility and awareness of staff with regards to the most up to date evidence based practice and health and safety guidelines. In order to ensure the safety of women using water birth facilities, the BCUHB Women's Directorate provides an annual update training event on water birth. This is attended by all midwifery staff and is led by the Midwifery Lead Unit (MLU) leads.</p> <p>A record of training compliance is then recorded on the training database and monitored to ensure updates are provided to staff teams in a timely manner. In addition, each unit has in place water birth procedures, which is available to all staff to access and read. Matron support is readily available at any time. During the C-19 pandemic, full drills in relation to mock medical emergencies have not taken place, and so a training video with training support has been provided.</p> <p>Finally, matron's encourage the awareness of staff responsibilities and adherence with protocols, by observing midwives in practice. Feedback is provided and shadowing encouraged as and when required</p>	<p>Professional Development Lead</p> <p>Midwifery Led Unit Lead</p> <p>Maternity Matrons</p>	Completed

## Recommendation

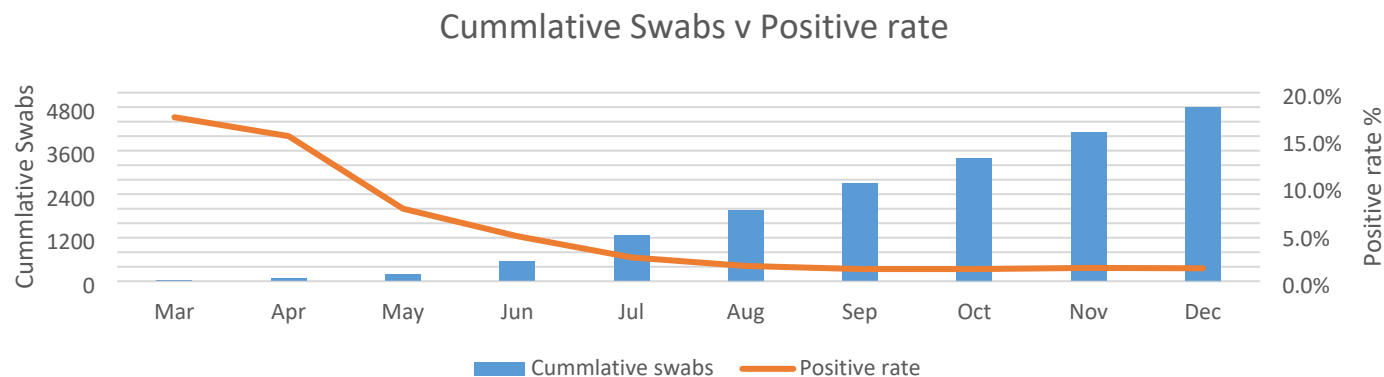
### 16. Ensure that a clutter free and safe environment is maintained across units.

Action	Responsible Officer	Timescale
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<p>Ensuring a safe and clutter free environment is a top priority across the Women's Directorate, and is promoted in line with Infection Prevention Control (IPC) and Health and Safety regulations. All members of staff attend IPC, Health and Safety mandatory training and matrons who manage each site, provide leadership to their teams by regularly assessing the environment as part of their mandatory audit plans.</p> <p>Working with ward housekeepers is also crucial and housekeepers are responsible for checking toilet and bathing facilities to ensure they are clean and conducive for use, with recorded checks in place to enable an audit trail. Ward managers and matrons complete weekly and monthly ward accreditation audits that includes an assessment on safe and clutter free environments. Audit results are included on the Women's Directorate Quality, Safety and Experience group meetings and any areas for improvement are noted and actions taken accordingly.</p> <p>As part of BCUHB's capital estate plans, the Women's Directorate have named a number of priorities that will support a safe and clutter free environment, such as refurbishments of each acute maternity unit across North Wales and community midwifery office accommodation. Health and Safety colleagues work closely with maternity services to help provide advice and support as and when required.</p> <p>Finally, Safe Clean Care-Harm Free self –assessment- Level 2: The Women's Directorate have submitted 34 of the action points with a plan to achieve level 4 for all 40 action points within a 3 months' timescale as seen attached.</p> <div data-bbox="568 896 629 959" data-label="Image"> </div> <p>SAFECLEAN.docx</p>	<p>Head of Women's Services</p> <p>Ward Managers and Site Matrons</p> <p>Head of Operational Services</p>	<p>Completed</p>
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Recommendation		
17. Ensure adequate infection control measures are in place, and adhered to.		
Action	Responsible Officer	Timescale

<p>Infection control measures (IPC) are stringently in place across all aspects of North Wales Women's services and compliance with IPC mandatory training is currently 87%.</p> <p>IPC audits are routinely completed as part of weekly ward accreditation and results are reported to the Women's Quality, Safety and Experience group on a monthly basis. The metrics include compliance with hand washing, bare below the elbow, intravenous cannula bundles and catheter insertion bundles. Results consistently demonstrate a 100% compliance rate, as also monitored through the Women's Directorate monthly accountability meetings.</p> <p>Alcohol gel for hand decontamination is provided at the entrance of each clinical area. Equipment and beds are identified as clean by appropriate signage. Personal protective equipment is accessible and its use has been subject to a weekly matron's audit involving compliance of women and their partners/family in wearing masks. All results to date have been encouraging.</p> <p>In relation to Covid-19, pathways across all services have been designed with ICP at the forefront of its application. This includes C19 swabs for all women entering the service, with segregated areas for women awaiting swab results. These measures have resulted in effective infection management control as seen below:</p>	<p>Head of Women's Services</p>	<p>Completed</p>
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Welsh Government guidance has also been locally interpreted to ensure restricted visiting and minimising infection is maintained across all hospital sites.

Relevant information about IPC is available for women and visitors on social media pages, upon admission to acute sites and from midwives across the board.

### Recommendation

#### 18. Ensure the safe storage of COSHH substances at all times.

Action	Responsible Officer	Timescale
<p>The Women's Directorate, manage the safe storage of COSHH as per BCUHB local policy; 'HS13 Control of Substances Hazardous to Health'.</p> <p>The above policy provides guidance to staff to ensure that all clinical areas where COSHH substances are used have completed a risk assessment that includes arrangements for the safe handling and storage. All maternity units have completed risk assessments with regular up to date</p>	Head of Women's Services	Completed



<p>reviews and all COSHH substances are stored in a designated marked and locked cupboard in each clinical area.</p> <p>A COSHH file is also available in all maternity units and in the community midwifery bases. It is the responsibility of the ward managers and community team leaders to keep the COSHH files up to date with risk assessments, inventory forms, training compliance and any other relevant information to that clinical area.</p> <p>Housekeepers are the designated COSHH leads and are required to attend a COSHH update session once every 3 years. This requirement is included in the Women's Services Training Needs Analysis.</p> <p>Compliance with correct storage of COSHH substances is included on the matrons' quality audits that are completed on a monthly basis and reported to the Women's Quality, Safety and Experience group.</p>	<p>Ward Managers and Community Team Leaders</p> <p>Housekeepers</p> <p>Maternity Matrons</p>	
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## Recommendation

### 19. Ensure that staff are aware of their responsibilities in relation to the safe storage of medication.

Action	Responsible Officer	Timescale
The safe storage of medication is a crucial part of staff mandatory training, with a 3 yearly medicine management module available through ESR. In addition to mandatory training, practice is monitored by the matron's weekly ward round, and an assessment of staff compliance against BCUHB policy, namely 'Medication Safety Alert: Safe Storage of Medicine'. Daily checking of controlled drugs and maintenance of drug fridge temperatures is also in place and routinely documented for audit purposes.	Head of Women's Services	Completed

## Recommendation

**20. Ensure that the prescription and administration of medication for the induction of labour is done in line with health board policy.**

Action	Responsible Officer	Timescale
The BCUHB Induction of Labour Policy (V.4) was updated in December 2019 by various clinical leads across the Women's Directorate, and is due for a review in December 2022. The policy is fully compliant with NICE guidelines and provides a pathway illustrating the prescription and administration requirements for induction of labour. The policy has been designed in line with best clinical practice and compliance is monitored via the annual audit cycle led by the consultant obstetrician teams. The next audit will take place alongside the 3 yearly policy review in December 2022.	Clinical Leads/Clinical Directors	Completed

## Recommendation

**21. Ensure women have access to Female Genital Mutilation clinics.**

Action	Responsible Officer	Timescale
BCUHB adhere to the 'All Wales Clinical Pathway for Female Genital Mutilation' which features on the obstetrician's annual audit cycle. FGM mandatory reporting is a legal duty, provided for in the FGM Act 2003 and as such, the Health Board has an FGM designated safeguarding lead.  As the incident rate is considered low at present in North Wales, BCUHB do not have a specified FGM clinic, however clinicians with expertise in this field, have been identified across all three sites and are available to provide specialist individualised advice and care management.	Clinical Lead/Clinical Directors	Completed

## Recommendation

**22. Ensure learning and service improvement actions are implemented following incidents, concerns of audit, is effectively shared with staff across all sites.**

Action	Responsible Officer	Timescale
<p>Service improvement is a key focus of the Women's Directorate Quality, Safety and Experience Group. Lessons learnt from incidents, concerns or audits are shared at this forum and in turn across the Directorate via relevant management/matron leads. Assurance reports are then developed and information cascaded up to the North Wales Women's Directorate Board meetings (once a month). Any actions taken as a result of learning or service improvement, is then monitored via the Women's Board and the Patient Quality and Safety Executive Group.</p> <p>Examples of past learning and service improvement is seen in the Women's Directorate 3 Year Strategy, which is the foundation of the services strategic plans. The priorities identified, enables transformation and growth across a wide range of maternity services, all of which, is in consultation with the Women's Voices Group.</p> <p>On a more practical level, a 'Risk Newsletter' is under development, to be published by January 2021 to include highlights of lessons learnt following incident reviews, concerns and audits which will then be disseminated across the directorate and made available to various stakeholder groups.</p> <p>Clinical Supervisors for Midwives also provide regular feedback to individual staff including themes and trends/lessons learned to group supervision sessions, based on incidents and Datix.</p> <p>All Learning from Events forms, Welsh Risk Pool and Welsh Government reportable items are shared at the Women's Quality, Safety and Experience group and cascaded widely to all clinicians in the Lessons Learnt Updates which are shared at meetings and by electronic means.</p> <p>Patient stories are also at the forefront of any committee meeting.</p>	<p>Head of Operational Services</p> <p>Governance and Risk Midwife</p> <p>Clinical Supervisors of Midwives</p>	<p>Completed</p>
Recommendation		

23. Ensure that steps are taken to encourage staff to speak up and report incidents without fear of reprisal or repercussion.

Action	Responsible Officer	Timescale
<p>BCUHB are in the process of reviewing the Health Board's 'Raising Concerns Safe Haven Process' and proposals are being developed by the executive team by March 2021 – REMAINS IN PROGRESS.</p> <p>The review recommendations include:</p> <ol style="list-style-type: none"> <li>1. Establishment of 2 Board level 'champions' and a role of Speak out Safety Guardian.</li> <li>2. Introduction of a system to support accessible reporting and engagement with reporters to enable two way conversations (including when reporter anonymous).</li> <li>3. Establishment of a Multi Disciplinary Speak out Safety Resolution &amp; Improvement Group.</li> <li>4. Development of a learning and reporting cycle.</li> <li>5. Review of revision of the existing Policy and guidance.</li> <li>6. Develop roles for speak out safely leads/aligned with listening/wellbeing leads.</li> </ol> <p>The Dignity at Work Policy is also under review at an All Wales level.</p> <p>Staffing across the Women's Directorate are actively encouraged to speak up and/or report an incident with support from matrons, operational leads, clinical supervisors for midwives and during management ward rounds. In particular the Director of Women's Services provides staff drop in sessions during monthly service reviews and actively seek feedback from staff. This also provide an opportunity to all staff to approach senior management to raise any concerns, on a monthly basis.</p>	<p>Executive Director WOD</p> <p>Head of Operational Services</p>	<p>April 2021</p>

<p>The Datix System is also accessible and readily available to input any concerns and is indeed used on a daily basis. Furthermore, should a serious incident occur, CSfM's support staff during the incident review process, making it clear the need not to apportion a blame culture.</p> <p>An example of the steps taken to encourage staff to 'speak up' is the recent quality improvement initiative that took place in the West area (September to December 2020). A letter was presented on behalf of the midwifery team to senior management in the summer of 2020 outlining concerns regarding workforce and culture. As a result, a service improvement panel was developed that involved staff representatives and a staff evaluation process. By the end of December 2020, significant improvement was noted in terms of how staff felt, especially the ability to speak open and honestly. A 'You Said/We Did' approach supported the overall improvement work, including logical models and a SMART action plan.</p> <p>Finally, a new initiative named 'Random Acts of Kindness' is proposed for implementation by March 2021.</p>		
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## Recommendation

### 24. Ensure the timely implementation of a single maternity dashboard across Wales.

Action	Responsible Officer	Timescale
The Wales Maternity & Neonatal Network have agreed to develop a national maternity dashboard and are currently reviewing all risk triggers for reporting of incidents. Following standardisation of the incident reporting process, the Network will be developing of a single Dashboard for Wales and all Health Board will be informed of progress at a later date.	Wales Maternity & Neonatal Network	TBC 2021/22

## Recommendation

**25. Ensure that policies and procedures are updated, ensuring staff are aware of updates to maintain the delivery of safe and effective care.**

Action	Responsible Officer	Timescale
<p>The BCUHB Women's Directorate have in place a robust Written Control Document (WCD) Working Group who meet on a monthly basis. This group reviews and monitors the register of all written control documents, including emerging guidelines, those due for review and compliance against NICE guidance and quality standards. In March 2021, our compliance for completed WCD's has reached 73%.</p> <p>Various maternity forums are then approached to consider new guidance/policy as required. Clinicians take lead in the development of documents and each WCD is rag rated with a designated lead for review.</p> <p>Staff awareness of new or reviewed policies is raised at the Women's Quality, Safety &amp; Experience Group, who ratifies all written control documents, which is then followed by the North Wales Women's Board. Where necessary the BCUHB Drug &amp; Therapeutics Group and/or Patient Safety and Quality Executive meeting, prior to any upload onto the intranet page. This process and approval route coincides with BCUHB's 'Policy on Policy'.</p> <p>An email is then circulated to all senior staff for cascade within their teams as soon as a new or revised guideline has been uploaded.</p> <p>The overarching Health Board Policy 'Policy on Policies' is under review by the office of the Board Secretary and will be updated following completion of the current governance review.</p>	<p>Head of Operational Service</p>          <p>Office of the Board Secretary</p>	<p>May 2021 – Target 90%</p>          <p>September 2021 (subject to COVID pressure)</p>

Recommendation		
<b>26. Ensure all midwives complete appropriate training before being required to assist in theatre.</b>		
Action	Responsible Officer	Timescale
BCUHB midwives do not assist in theatre.	N/A	N/A

Recommendation		
<b>27. Consider the implementation of champion midwives to support further innovation and research.</b>		
Action	Responsible Officer	Timescale
<p>BCUHB Women's Directorate have in place an Improvement Midwife who leads on service improvement plans and innovation to ensure the delivery of high quality care, to meets the needs of women and babies across North Wales.</p> <p>An example of the standard of care provision and improvement work is the antenatal detection of Small for Gestational Age Babies and the reduction of the BCUHB error rate in New-born Blood Spot screening tests. This work was nationally recognised and the BCUHB Improvement Midwife was nominated for an Improvement Award.</p> <p>In terms of other research and audit needs, midwives are regularly seconded into temporary posts to complete specific pieces of work and provide feedback via the Women's Directorate clinical audit group.</p> <p>A designated research midwife works across North Wales and supports midwifery services and wider Health Board Research Projects.</p>	Head of Operational Services	Completed

In February 2021, the Women's Directorate welcomed our new Consultant Midwife who will also be leading on improvement and innovation across all services.		
<b>Recommendation</b>		
<b>28. Consider the introduction of live stream CTG monitoring in all units.</b>		
<b>Action</b>	<b>Responsible Officer</b>	<b>Timescale</b>
<ul style="list-style-type: none"> <li>Livestream CTG has been introduced in Wrexham Maelor Hospital, with central monitoring in each of the units.</li> </ul>	Clinical Leads/Clinical Directors	Completed
<b>Recommendation</b>		
<b>29. Ensure that staff have timely access to the training that is required for them to carry out their roles effectively.</b>		
<b>Action</b>	<b>Responsible Officer</b>	<b>Timescale</b>
<p>The BCUHB Women's Directorate have a rolling high compliance rate of mandatory training across midwifery, medical and operational teams, which is consistently recorded above 85%.</p> <p>All staff attend their mandatory training and PROMPT training annually, which is monitored via line managers and monthly accountability meetings. Staff returning from maternity leave and long term absence are prioritised to attend at the earliest opportunity. Attendance and compliance is recorded on ESR and the Women's Directorate training database on share point.</p> <p>During the covid-19 pandemic, some face-to-face training sessions were unable to take place, therefore training was held virtually. PROMPT training recommenced in September 2020 which</p>	Professional Development Lead	<p>April 2021 (subject to COVID pressure)</p> <p>WG Target August 2021</p>



followed a prioritisation schedule, with a current compliance rate of Midwifery staffing 74% and medical staffing 80%. A 100% compliance target is aimed for August 2021. Additional PROMPT courses have been arranged on each site in order to achieve this target.		
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## Recommendation

**30. Review their workforce plans to ensure appropriate actions are being taken to address the impact of staff working excessive hours, and any shortfall across staff groups.**

Action	Responsible Officer	Timescale
<p>The Medical Establishment is aligned to the RCOG Workforce Standards.</p> <p>The BCUHB Midwifery staff (both budgeted posts and actual) reflect the Birth Rate Plus audit that was completed by the Birth Rate Plus Consultancy in April 2020. Recent midwifery recruitment attempts proved successful with 50 midwives applying for limited number of posts from across the UK.</p> <p>A pilot on call system for hospital midwives commenced in 2019, with the objective of ensuring 'Appropriate Skills for Appropriate Places'. The community midwives on call system is reserved for home births and other community activity with the aim of preventing unnecessary hospital attendance for women at low risk.</p> <p>Excessive hours are managed as per the Health Board Roster Policy and daily exception reporting monitored by the site midwifery leadership teams. Time worked in excess of contracted hours is managed as per the Health Board Time Off in Lieu (TOIL) Policy.</p> <p>Staff break 'logs' have recently been established, which was welcomed as a supportive measure, to ensure staff receive necessary breaks and do not work excessive hours.</p>	<p>North Wales Medical Lead</p> <p>Director of Midwifery and Women's Services</p> <p>Head of Operational Services</p>	Completed

<p>All requests for bank shifts, additional hours and overtime shifts are submitted to the Head of Women's Service, prior to final approval from the Director of Women's Services and the North Wales Medical Lead. In terms of the medical workforce, plans include rota coordination, workforce reviews, monitoring vacancies and individual job plans are managed by the Head of Operational Services in conjunction with the North Wales Clinical Lead.</p> <p>Medical Job Planning Reviews have taken place across each site during March and training to be provided from the Medical Director's Office in relation to 'Allocate'. Awaiting BCUHB Job Planning Policy to be finalised.</p>		
<b>Recommendation</b>		
<b>31. Consider implementation of positive initiatives to recognise the good work carried out by staff within the midwifery and medical teams.</b>		
<b>Action</b>	<b>Responsible Officer</b>	<b>Timescale</b>
<p>The BCUHB Women's Directorate recognize the good work of staff in a variety of ways. A 'BEVI Award' was recently implemented whereby members of staff were invited to nominate individual staff who had demonstrated kindness or support for colleagues or women in their care. The individuals with the most nominations are now presented with a BEVI certificate, which takes place on a monthly basis. This has proven beneficial in helping to raise staff morale during the Covid Pandemic.</p> <p>Furthermore, expressions of interest were requested, across Women's Services, seeking individual staff members to become staff ambassadors. Six expressions of interest were received, all of whom took up the role and are now advocates for staff wellbeing and representing staff with any concerns.</p> <p>BCUHB have also launched a 'Be Proud Pioneer Program', which runs over a 26-week period. The aim of the Program is to work with specific teams to encourage engagement through different tools of coaching. The Program consists of different workshops and ways of learning such as how to build relationships. Initial evaluation of the Program is that it has helped staff to feel valued, resulting in</p>	<p>Women's Senior Management Team</p> <p>Head of Operational Services</p>	<p>Completed</p>

<p>better working relationships, reduced sickness levels and increased staff morale. The six staff ambassadors have also been invited to attend the Be Proud Pioneer Program.</p> <p>Newsletters are under development for 2021 to include good news stories and learning from patient experience and stories.</p> <p>Finally, a 'Random Act of Kindness' Pilot will commence in March 2021, which encourages values in practice, teamwork, recognition as well as supporting staff wellbeing. This will include a kindness calendar, posters for staff rooms, kindness award certificates and 'Tag Your It' cards.</p>		
<b>Recommendation</b>		
<b>32. Ensure that a high standard of documentation is maintained, in particular ensuring that the standard of patient records is improved.</b>		
<b>Action</b>	<b>Responsible Officer</b>	<b>Timescale</b>
<p>The Clinical Supervisors for Midwives (CSfM) follow a number of processes to ensure high standards of record keeping is maintained across BCUHB's Women's Directorate. This includes providing documentation-training sessions, included in the midwives training schedule, and undertaking audits of notes, reporting findings to senior management.</p> <p>It is also a requirement across BCUHB, that all midwives conduct their own annual documentation audit, consisting of two randomised case notes, following a specific method that sets out any themes or issues for learning. The results of these audits are included within the annual documentation learning session, as organised by the CSfM's.</p> <p>It is planned that from Summer 2021, documentation training will be delivered as a mandatory stand-alone session for all midwives. The medical teams also receive record keeping training and have access to support from operational teams with any record keeping issues.</p> <p>Monitoring high levels of standards for record keeping is done by the matron's quality assurance ward round on a monthly basis and results are provided to the Women's QSE Group.</p>	<p>Head of Women's Services/Maternity Matrons</p> <p>Clinical Supervisors for Midwives</p>	<p>July 2021</p>

BCUHB also undertake a ward accreditation program that independently assesses the quality and standard of services provided across the organisation.		
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<b>Cyfarfod a dyddiad: Meeting and date:</b>	Quality, Safety & Experience (QSE) Committee 4 <sup>th</sup> May 2021						
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public						
<b>Teitl yr Adroddiad Report Title:</b>	Quality Governance Self-Assessment Action Plan (Maternity Services)						
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
<b>Awdur yr Adroddiad Report Author:</b>	Matthew Joyes, Acting Associate Director of Quality Assurance Julie Ward Jones, Head of Quality Assurance						
<b>Craffu blaenorol: Prior Scrutiny:</b>	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
<b>Atodiadau Appendices:</b>	1. Quality Governance Self-Assessment Action Plan						
<b>Argymhelliad / Recommendation:</b>							
The Committee is asked to note the report and update of the Quality Governance Self-Assessment Action Plan.							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>	✓	<b>Er gwybodaeth For Information</b>	
<b>Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable</b>						<b>N</b>	
<b>Sefyllfa / Situation:</b>							
Following submission of the Quality Governance Self-Assessment to Welsh Government on 07 January 2020, an action plan (Appendix 1) was developed that recorded each action identified in the submission and a lead officer and target date.							
This update is being provided for assurance to the Committee that ongoing delivery and monitoring is continuing.							
<b>Cefndir / Background:</b>							
Following well publicised events at Cwm Taf Morgannwg University Health Board, the Royal College of Obstetricians & Gynaecologists (RCOG) was commissioned by the Welsh Government to undertake an external review to investigate the care provided by the health board's maternity services. The review took place on 15-17 January 2019, and at the request of Welsh Government, the resulting report and its findings/recommendations informed a local benchmarking exercise involving health boards across Wales. Each Health Board was asked to consider its own maternity services in the context of the recommendations of the report and to provide assurances on the safety							

of those services. The Women's Directorate in the Health Board undertook this benchmarking exercise and submitted the outcome to Welsh Government in May 2019. Some areas for ongoing improvement were identified and have been taken forward as part of the Directorate's learning culture and service development.

In November 2019 Healthcare Inspectorate Wales and the Wales Audit Office issued a report titled 'A review of quality governance arrangements at Cwm Taf Morgannwg University Health Board'. The Minister for Health and Social Services requested that all health boards and NHS trusts in Wales assess themselves against the recommendations of the review and provide plans for future review of their arrangements and/or the necessary action to be undertaken. The self-assessment was required to include a narrative of current arrangements and the current level of assurance as high, medium or low.

The Board held an extraordinary workshop session in December 2019 as part of its process for determining its self-assessment response. The approved version of the response was submitted to Welsh Government on 07 January 2020 and reported to the QSE Committee that month.

The self-assessment response sets out the Health Board's current position across 7 areas:

- Strategic focus on quality, patient safety and risk
- Leadership of quality and patient safety
- Organisational scrutiny of quality and patient safety
- Arrangements for quality and patient safety at directorate level
- Identification and management of risk
- Management of incidents, concerns and complaints
- Organisational culture and learning

Levels of assurance, based on the current position, were allocated, based on the following definitions: 'a self-assessment of 'high' indicates substantial assurance on the effectiveness of the quality governance arrangement in question, with few or no matters requiring attention. 'Medium' indicates reasonable assurance, with some matters requiring management attention. 'Low' indicates limited or no assurance, with more significant matters requiring management attention'.

## **Asesiad / Assessment & Analysis**

The achievement of the actions in this plan will help strengthen governance arrangements within the Health Board. The Corporate Quality Assurance Teams continues to monitor this plan and collate evidence against each completed action (which is being stored in a central file directory).

A number of actions are rated as Amber and in these cases target dates have been amended. These changes are due to the COVID-10 second wave and need to prioritise clinical service delivery.

Previous updates have been sent to the QSE Committee and Joint Audit and QSE Committee.

It is proposed that updates continue to be provided to the QSE Committee until such times as the actions are complete, a full evidence repository if collated and the Committee assured.

**Goblygiadau Strategol / Strategy Implications** – Not applicable.

**Opsiynau a ystyriwyd / Options considered** - Not applicable.

**Goblygiadau Ariannol / Financial Implications** – Not applicable.

**Dadansoddiad Risk / Risk Analysis** – This is contained within the report.

**Cyfreithiol a Chydymffurfiaeth / Legal and Compliance** – This is contained within the report.

**Asesiad Effaith / Impact Assessment** – Impact assessments are not required for this report.



### BCUHB Quality Governance Self-Assessment Action Plan

*[For the purposes of the following table, a self-assessment of 'high' indicates substantial assurance on the effectiveness of the quality governance arrangement in question, with few or no matters requiring attention. 'Medium' indicates reasonable assurance, with some matters requiring management attention. 'Low' indicates limited or no assurance, with more significant matters requiring management attention]*

<b>Recommendation 1 - Organisational quality priorities and outcomes to support quality and patient safety are agreed and reflected within an updated version of the Health Board's Quality Strategy/Plan.</b>				
<b>Action</b>	<b>Lead</b>	<b>Deadline</b>	<b>Update</b>	<b>RAG Status</b> Green: Complete Amber: On Track Red: Overdue
<p><b>Strategic Focus on Quality, Patient Safety and Risk [baseline level of assurance – Medium]</b></p> <p>1a. Production of an updated QIS: The QIS is currently being reviewed and is undergoing an Internal Audit Review. The findings from the Audit will be used to shape the revised QIS alongside the agreed priorities for the Health Board. Timeline for approval –</p>	Matthew Joyes, Acting Associate Director of Quality Assurance	<p>31/03/2021</p> <p>New proposed timescale 30 June 2021</p>	Development of the Quality Strategy has been on hold due to the need to respond to the Covid-19 pandemic second wave. A plan for resuming this work and producing an updated QS is now in place.	



workshop proposed for February 2020, then QSE and approval at May 2020 Board.				
<p>1b. Production of a Clinical Strategy: A detailed timeline for the Clinical Strategy is being developed.</p> <p>Timescales – agreed priority by end of march 2021 – agreed signed off process how going forward by Board</p>	Arpan Guha, Interim Executive Medical Director	<p>31/03/2021</p> <p>New proposed timescale 31/12/2021</p>	<p>This work is now being taken forward as part of a joint refresh of LHSW and development of the Clinical Strategy, led by the CEO. Please note the proposed timescale may change to align with the refresh of LHSW and development of the IMTP.</p>	
<p>1c. Production of Communication Plan: Alongside the development of the QIS, Clinical Strategy and Annual Plan will be a communication plan, which will ensure effective dissemination across the Health Board.</p>	Matthew Joyes, Acting Associate Director of Quality Assurance	<p>31/03/2021</p> <p>New proposed timescale 30 June 2021</p>	<p>The development of the Communication Plan will follow the timeline of the key strategic documents to which it is linked This work will be picked up again as part of the return to business as usual.</p> <p>See 1A update</p>	

<p><b>Recommendation 2 - The Board has a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically:</b></p> <ul style="list-style-type: none"> <li><b>i. The Board Assurance Framework (BAF) reflects the objectives set out in the current Integrated Medium Term Plan (IMTP)/annual plan and the organisation's quality priorities.</b></li> <li><b>ii. The Risk Management Strategy reflects the oversight arrangements for the BAF, the Quality and Patient Safety (Clinical) Governance Framework and any changes to the management of risk within the organisation.</b></li> <li><b>iii. The Quality and Patient Safety Governance Framework supports the priorities set out in the Quality Strategy/Plan and align to the Values and Behaviours Framework.</b></li> </ul> <p><b>Terms of reference for the relevant Board committees, including those for Audit, Quality and Safety and Risk, and at divisional /group levels, reflect the latest governance arrangements cited within the relevant strategies and frameworks</b></p>				
<b>Action</b>	<b>Lead</b>	<b>Deadline</b>	<b>Update</b>	
<p><b><i>[Baseline level of assurance – low/medium]</i></b></p> <p>2a. Once ratified by the Board, monitor implementation of updated Risk Management Strategy and audit key performance indicators, formally reporting results to the Risk Management Group.</p>	Justine Parry, Assistant Director of Information	30/09/2020	The Risk Management Strategy and associated procedural documents and protocols have been updated, and the new	

	Governance and Risk		<p>strategy ratified by the Board on the 23<sup>rd</sup> July 2020.</p> <p>The Health Board has also streamlined its risk management process, clearly defining its risk management process and framework, moving from a 5 to 3 tier risk management approach from 1<sup>st</sup> October 2020.</p> <p>Training has been and will continue to be delivered to staff across the Health Board as part of developing and building local capacity, knowledge and awareness of effective risk management in supporting and embedding a positive risk aware culture.</p> <p>Risk Management Strategy KPIs will commence formal reporting to the Risk Management Group during October 2020 with assurance provided to the Audit Committee as part of the RMG Chairs Assurance Report.</p> <p>Risk Management KPIs include:</p>	
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			<p><b>Compliance:</b> This will measure whether the Health Board is compliant with its own risk management strategy and policy by evaluating the following components:-</p> <ul style="list-style-type: none"> <li>• % of risks in the Directorate reviewed in line with the Risk Management Strategy and Policy;</li> <li>• % of risks which are in date and/or out of date;</li> <li>• % of actions linked to Directorate risks which have been completed within set timescales.</li> </ul> <p><b>Maturity:</b> This measure will focus on evaluating the completeness of risks on risk registers across the Health Board and will concentrate on the following aspects: -</p> <p>92.97% of risks with risk lead/manager and specialty amongst other key fields appropriately completed.</p>	
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<p>2b. Provide Chairs' Assurance Report from the Risk Management Group on progress and outcomes to the Audit Committee.</p>	<p>Justine Parry, Assistant Director of Information Governance and Risk</p>	<p>30/09/2020</p>	<p>See 2a above – linked to launch of new Strategy.</p> <p>The RMG Chair's assurance report provides confidence to the Audit Committee of the work the group is doing in reviewing, monitoring and ensuring the effective implementation of robust systems, processes and governance arrangements across the Health Board in engineering and embedding an excellent risk management culture as part of Good Governance.</p> <p>The Risk Management Strategy V5.0 approved on the 23<sup>rd</sup> July 2020 was launched on 1<sup>st</sup> October 2020 with the move from the 5 to 3 tiers. The new strategy provides an overarching perspective on the Health Board's vision, philosophy and approach to risk management across.</p>	
<p>2c. Deliver training to key individuals and groups across whole Health Board to provide consistent approach for the management of risk, the hierarchy for training will be</p>	<p>Justine Parry, Assistant Director of Information</p>	<p>30/09/2020</p>	<p>As part of embedding its new Risk Management Strategy, the Health Board recently sourced the services of an external risk</p>	

developed alongside strong monitoring arrangements.	Governance and Risk		<p>management specialist to deliver six risk virtual management training sessions to senior managers across the organisation. The corporate risk team will continue to deliver this training through the rest of the year and this will be reinforced further training resources around 'How to add a new risk onto Datix' and updating of the corporate induction pack to include components on risk management.</p> <p>Monitoring of this training will continue and has been incorporated into the Risk Management Training Plan.</p> <p>Risk reporting, monitoring, scrutiny, escalation, de-escalation, governance, accountability and oversight are key strands of the new strategy and clearly defined reporting and monitoring arrangements in place.</p>	
2d. Ensure the RM Group meets at least 4 times during the year.	Justine Parry, Assistant Director of Information	30/09/2020	The Risk Management Group has a clearly defined Terms of Reference and Cycle of Business which define that it	

	Governance and Risk		needs to meet more than 4 times a year. The cycle of business provides a framework on Divisional rotatory risk reporting on how Divisions are effectively mitigating and managing their risks.	
2e. Ensure all risks within DATIX are realigned to the new 3-tier model.	Justine Parry, Assistant Director of Information Governance and Risk	30/09/2020	As defined in the new Risk Management Strategy, the Health Board has moved from a 5 to 3 risk management model. Risk owners have reviewed, updated and re-scored their risks on Datix in readiness for the switch to the 3 tier which took place on 1 <sup>st</sup> October 2020. All risks on Datix are now aligned to the 3 tier approach as defined in our new Risk Management Strategy. Work is ongoing in supporting Divisions to continue to review and appropriately score all their risks	
2f. Principal risks to be presented to the Board at a further workshop to agree and review in line with the current CRAF arrangements.	Dawn Sharp, Deputy Board Secretary	31/03/2021	On 21 <sup>st</sup> January 2021, the Board approved the implementation of the revised Board Assurance Framework (BAF) template reporting arrangements.	

			<p>This new design captures the work undertaken by the Board on the identification of its Priority Areas to support the effective management of the agreed Principal Risks that could affect the achievement of its agreed Priorities following a workshop held on 22.9.20. This has led to streamlining and re-design of the Corporate Risk Register (CRR), which more effectively demonstrates how the Health Board is robustly mitigating and managing extreme risks to the achievement of its operational objectives. The respective elements of the BAF are presented to the relevant Board Committee following regular review with the Leads. Further review and refinement of the BAF risks in the context of the draft annual plan (2021/22) and risk appetite is scheduled to take place at the Board Workshop on 27<sup>th</sup> April 2021.</p>	
2g. Ensure the new approach to the BAF will align to the organisational priorities from a risk and quality perspective.	Dawn Sharp, Deputy Board Secretary	31/03/2021	<p>Following on from previous Executive workshops and Board workshops, a new BAF has been designed following a Risk</p>	



			Management Board Workshop held on 22 <sup>nd</sup> September 2020 during which the Health Board's Strategic Priorities were identified, articulated and defined. Principal risks which could inhibit the achievement of the Strategic Priorities have also been identified and have been incorporated into the BAF.	
2h. Develop Patient Safety Strategy and review all other pillars of the Quality and Patient Safety Governance Framework to ensure full alignment with the work programme to strengthen governance across the organisation.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021  New proposed timescale 30 June 2021	See action in 1a – this work is aligned to the Quality Strategy.	
2i. Undertake Governance Review led by the Deputy CEO: This review will seek to ensure that there is clear alignment and escalation of risks to the Board as appropriate and reflect the latest governance arrangements as cited within the relevant strategies and frameworks.	Simon Evans-Evans, Interim Governance Director	31/03/2021  New proposed timescale 30 June 2021	The governance review is progressing in line with reports to the Board and Executive Team	
<b><i>Recommendation 3 - There is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads:</i></b>				

<p><b>i. The role of Executive Clinical Directors and divisional/group Clinical Directors in relation to quality and patient safety is clearly defined</b></p> <p><b>ii. The roles, responsibilities, accountability and governance in relation to quality and patient safety within the divisions/groups/directorates is clear</b></p> <p><b>There is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety.</b></p>				
Action	Lead	Deadline	Update	
<p><b>[Leadership of Quality and Patient Safety. Baseline level of assurance – Low]</b></p> <p>3a. Establish Clinical Leads for new pathways and networks: In addition to Clinical Directors, Lead Consultants and Lead Clinicians, the Health Board will be establishing Clinical Leads for the new pathways and networks as part of the new digitally enabled clinical strategy.</p>	Arpan Guha, Acting Executive Medical Director	<p>31/12/2020</p> <p>New proposed timescale 31 March 2021</p>	<p>Executive Team discussion took place on 20.5.20 regarding the future model of clinical engagement, capitalising on the success of the Clinical Advisory Group established as part of the Covid-19 response. The CAG has demonstrated how clinical input and leadership can augment the (Covid-19) clinical pathway development process, and how this might be optimised for business as usual in future. Broadening the membership of CAG's successor group, and utilisation of key individuals such as Cluster Leads, will provide enhanced options for identifying Clinical Leads for pathways and networks.</p>	

			As the clinical strategy is being re-thought, this action, linked to that old strategy, is superseded.	
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3b. Governance Review being led by Deputy CEO to clarify and make recommendations to strengthen any arrangements where felt appropriate; this will include the composition of the local governance teams across BCUHB.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021  New proposed timescale 30 September 2021	See action in 2i – The governance review is progressing in line with reports to the Board and Executive Team.  Acute and MHL D governance teams have been aligned. A bespoke solution has been with Women's. Consultation is due to start with Areas. The completion date is dictated by consultation processes.	
3c. Learning from the HIW review of Maternity Services and Birth Centres to be used to strengthen internal processes.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/12/2020	A comprehensive action plan has been developed in response to the national review, in-line with national work and has been approved by PSQ and reported via QSE.	
3d. Governance review to further support work already undertaken by assessing if failings and gaps identified within Cwm Taf exist within BCUHB and ensure that where these are identified strengthened and improved. This will include the use of data and dashboards for and how these are reported through to the Board.	Matthew Joyes, Acting Associate Director of Quality Assurance (quality governance) and Simon Evans-Evans,	31/12/2020  New proposed timescale 30 June 2021	See action in 2i – The governance review is progressing in line with reports to the Board and Executive Team. The QSG meeting has been aligned to the three quality domains allowing greater scope for discussion and scrutiny.  A new Quality Dashboard is in development. Pilot taken place.	

	Interim Governance Director (corporate governance)		Roll out across the Health Board planned for completion by end of May 2021  A Concerns (Patient Safety and Experience) performance dashboard is in place.	
<b><i>Recommendation 4 - The roles and function of the Quality and Safety Committee is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety Governance Framework and key corporate risks for quality and patient safety. This should include assessment of ensuring sub-groups/committees have sufficient support to function effectively; the content, analysis, clarity and transparency of information presented to the committee and the quality framework in place is used to improve oversight of quality and patient safety across the whole organisation.</i></b>				
Action	Lead	Deadline	Update	
<b><i>[Organisational scrutiny of quality and patient safety. Baseline level of assurance – Low/Medium]</i></b>  4a. Governance Review will provide further opportunity to ensure fitness for purpose of the overall structure, reporting and escalation. Following the review implementation of the recommendations of the will be monitored by QSE.	Simon Evans-Evans, Interim Corporate Governance Director	31/12/2020  New proposed timescale 30 June 2021	See action in 2i – The governance review is progressing in line with reports to the Board and Executive Team.	

4b. Function and remit of QSE Committee, and cycle of business, to be reviewed to ensure that the Committee is operating effectively and sufficient focus is given to the quality, safety and experience priorities for the organisation. This will also provide an opportunity for the CBMG to reflect on the reporting arrangements across the different committees to ensure sufficient clarity and oversight at Board level.	Simon Evans-Evans, Interim Corporate Governance Director	31/12/2020  New proposed timescale 30 June 2021	See action in 2i – The governance review is progressing in line with reports to the Board and Executive Team.	
4c. Broadening of the visibility of the QPSE dashboard as well as other metrics within the internal viewing system IRIS to be undertaken alongside the development of the Clinical Strategy.	Matthew Joyes, Acting Associate Director of Quality Assurance	30/09/2020  New proposed timescale 30 June 2021	See 3d update - A new Quality Dashboard is in development. Pilot taken place. Roll out across the Health Board planned for completion by end of May 2021	
<i>Recommendation 5 - Independent/Non-Executive Members are appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them.</i>				
Action	Lead	Deadline	Update	
<b>[Baseline level of assurance – Medium]</b>				
5a. Ensure that the Board Development and Workshop programme is strengthened to include all elements within the IM role e.g. Consultant Interviews. And consider feedback	Louise Brereton Board Secretary	30/04/2021	Board Development and Workshop programme in place during 2020/21, which was modified in terms of delivery to take account of Covid	

from the work with the King's Fund which will further support the development programme for IMs			restrictions. This programme came to an end during Q4 2020/21 and a tendering exercise is currently underway (March 2021) to secure a continuation of the programme particularly in view of Board turnover during the year. In terms of Consultant Interviews training and support this has been facilitated by Workforce colleagues outside of the Board Development programme with additional support provided with the move to virtual platforms.	
<i>Recommendation 6 - There is sufficient focus and resources given to gathering, analysing, monitoring and learning from user/patient experience across the organisation. This must include use of real-time user/ patient feedback.</i>				
Action	Lead	Deadline	Update	
<p><b>[Baseline level of assurance – Medium]</b></p> <p>6a. Greater emphasis to be placed on the “learning element of listening to patients and services users” throughout 2020 as described in the Patient Experience Strategy, this will include the “You said, We did” approach.</p>	Matthew Joyes, Acting Associate Director of Quality Assurance	<p>31/03/2021</p> <p>New proposed timescale 30 June 2021</p>	See action in 1a – this work is aligned to the Quality Strategy.	

6b. Review the processes for concerns (incidents, complaints, claims, etc.) - the Community Health Council will be a key part of this work.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/01/2020  New proposed timescale 30 June 2021	As a result of the COVID-19 second wave, this work has been delayed. Implementation is underway in April 2021 with full implementation by the end of Q1.	
6c. Hold a workshop planned jointly with the CHC, to strengthen how the complaints and patient experience teams within the Health Board, and the CHC, work more closely together.	Matthew Joyes, Acting Associate Director of Quality Assurance	28/02/2020	Complete. The workshop with the CHC was held and following internal review a new senior complaints lead has been appointed to maintain oversight of all CHC complaints develop relationships.	
<i>Recommendation 7 - There is visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.</i>				
Action	Lead	Deadline	Update	
<b>[Baseline level of assurance – Low]</b>  7a. Embed arrangements following adoption of revised Clinical Audit Policy.	Melanie Maxwell, Senior Associate Medical Director	31/12/2020	The Clinical Audit Policy was approved by the Audit Committee; arrangements will be embedded as part of the return to business as usual.	



			<p>To be discussed under Any Other Urgent Business for Clinical Effectiveness meeting on 15 October 2020</p> <p>Clinical Audit Policy updated approved at Clinical Effectiveness Group In March 2021</p>	
<p>7b. Review the clinical audit plan and reporting arrangements, including identification of outliers and learning, to ensure that it is outcome focussed and facilitates quality improvement activities across the organisation – monitor progress through the governance reporting structure going forwards.</p>	<p>Melanie Maxwell, Senior Associate Medical Director</p>	<p>31/12/2020</p>	<p>This work has been paused due to Covid-19.</p> <p>To be mentioned under Any Other Urgent Business for Clinical Effectiveness meeting on 15 October 2020- to be discussed with Chair and member of the group. Clinical Audit Plan is monitored by Clinical Effectiveness Group Included in Cycle of Business for quarterly review</p>	

<b>Recommendation 8 - The organisation has clear lines of accountability and responsibility for quality and patient safety within divisions/groups/directorates.</b>				
<b>Action</b>	<b>Lead</b>	<b>Deadline</b>	<b>Update</b>	
<p><b>[Arrangements for quality and safety at directorate level.</b></p> <p><b>Baseline level of assurance – Low/Medium]</b></p> <p>8a. Complete work to formally identify a Clinical Director for each speciality - as part of the governance review, ensure that reporting lines and structures are fully considered and recommendations to strengthen/improve made.</p>	Arpan Guha, Acting Executive Medical Director	31/12/2020	The Medical Director has conducted an evaluation to ensure this action is complete.	
<p><b>Recommendation 9 - The form and function of the divisional/group/directorate quality and safety and governance groups and Board committees have:</b></p> <ul style="list-style-type: none"> <li><b>i. Clear remits, appropriate membership and are held at appropriate frequently.</b></li> <li><b>ii. Sufficient focus, analysis and scrutiny of information in relation to quality and patient safety issues and actions.</b></li> <li><b>iii. Clarity of the role and decision-making powers of the committees.</b></li> </ul>				
<b>Action</b>	<b>Lead</b>	<b>Deadline</b>	<b>Update</b>	

<p><b><i>[Baseline level of assurance – Low/Medium]</i></b></p> <p>9a. Implement actions from the governance review (see section 4 above), where necessary in order to further strengthen this governance element.</p>	<p>Simon Evans-Evans, Interim Governance Director</p>	<p>31/03/2021</p> <p>New proposed timescale 30 June 2021</p>	<p>This work was paused due to Covid-19. See section 4 above.</p> <p>See section 4 above for updates.</p>	
<p><b><i>Recommendation 10 - The organisation has clear and comprehensive risk management systems at divisional/group/directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers and the management of those risks. This must be reflected in the risk strategy.</i></b></p>				
Action	Lead	Deadline	Update	
<p><b><u>[Identification and management of risk. Baseline level of assurance – Low/Medium]</u></b></p> <p>10a. Move to Enterprise Risk Management model and from a 5 Tier model to a 3 Tier version, to strengthen escalation and de-escalation processes.</p>	<p>Justine Parry, Assistant Director of Information Governance and Risk</p>	<p>31/09/2020</p>	<p>The new Risk Management Strategy supports an enterprise risk management approach as it moves from silo to an integrated organisational-wide model to effectively manage. It underlines the fact that BCU is committed to implementing an integrated, dynamic, inclusive, comprehensive, risk-based</p>	

			<p>approach to the delivery of its core operational and business activities. A risk-based approach will enable the Health Board to avoid unwelcome surprises by drawing and triangulating intelligence from multiple sources in implementing a dynamic, enterprise-wide perspective to the timely assessment, mitigation and management of emerging risks.</p> <p>The risk management process as defined in the new strategy draws inspiration from established risk management standards such as ISO 31000:2018 in highlighting the Health Board's risk management process from 'Ward to Board'.</p> <p>It provides high level assurance to key stakeholders through the use of tools like Self-assessments, Audits, KPIs reporting, regularly reports to Quality &amp; Safety and Governance meetings, committees and the Board.</p>	
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			<p>Staff are encouraged, trained and empowered to take local ownership and leadership for the effective risk management within their Services and Divisions. This will strengthen engagement, local ownership/decision making, streamline the process, encourage, joined-up, integration and greater visibility of identified risks through the governance arrangements. At the heart of the new Strategy is the implementation of Enterprise Risk Management (ERM) across BCU as staff will embed effective risk management through priority and objective setting, raising productivity, performance, better decision-making and ensuring financial viability.</p>	
10b. Implement and monitor revised Risk Management Policy.	Justine Parry, Assistant Director of Information Governance and Risk	31/09/2020	<p>See section 2a (KPI's to monitor policy). In addition to clearly defined KPIs as highlighted in 2a above for monitoring the new Strategy:</p> <p>-</p>	

			<ul style="list-style-type: none"> <li>- A suite of guidance and supporting documents have also been crafted and are available on the risk management intranet page to assist staff with reviewing, updating and re-scoring their.</li> <li>- A CQC-style Risk Management Self-assessment tool has also been developed and piloted at the YGC with the aim of supporting staff in undertaking self-evaluation of how they are doing with regards to risk management. The Corporate Risk Team will work with Divisions to develop their action plans to address any areas of short fall and monitor through to completion. See below embedded example.</li> <li>- The new Strategy advocates for a performance management approach to risk management and defines effective risk</li> </ul>	
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			management as a tool for continuous improvements in patient care.	
<b><i>Recommendation 11 - The oversight and governance of DATIX and other risk management systems ensures they are used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a divisional/group/ directorate or corporate level, and formal mechanisms to identify and share learning.</i></b>				
Action	Lead	Deadline	Update	
<b><i>[Management of incidents, concerns and complaints. Baseline level of assurance – Medium]</i></b>  11a. Ensure the Patient Safety Strategy strengthens reporting arrangements and focus on learning from all opportunities.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	See update in 1a - this work was put on hold due to Covid-19.	
11b. Ensure the Listening and Learning from Patient Experience Report and CLIC (Concerns, Litigation, Inspections, Claims) Report are reviewed and improved in order to provide the QSE Committee with further improved data and analysis, and a link to improvement activity	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2020	Complete. A new format Patient Safety Report and Patient and Carer Experience Report for QSE are both in place. Q4 reports were submitted to QSE and Q1 and Q2 reports for 2020/21 have been produced.	

11c. Ensure that the review of concerns/incidents/complaints/claims also includes a focus on HIW and CHC inspections/ visits as well as a link into risk management structures/ BAF in order to further strengthen triangulation	Matthew Joyes, Acting Associate Director of Quality Assurance	31/12/2020	New Patient Safety, Patient and Carer Experience and Quality Assurance Reports are now embedded.	
<b><i>Recommendation 12 - The organisation ensures staff receive appropriate training in the investigation and management of concerns (including incidents). In addition, staff are empowered to take ownership of concerns and take forward improvement actions and learning.</i></b>				
Action	Lead	Deadline	Update	
<b><i>[Baseline level of assurance – Medium]</i></b>  12a. Enhance the training programme for concerns with the introduction of a modular series of training and a passport scheme	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021  New proposed timescale 30 June 2021	This work was put on hold due to Covid-19. New training will be in place to support the new processes being implemented from April 2021. This training will link into the Ombudsman Complaints Standards Authority training programme.	
<b><i>Recommendation 13 - The organisation has an agreed Values and Behaviours Framework that is regularly reviewed, has been developed with staff and has a clear engagement programme for its implementation.</i></b>				



Action	Lead	Deadline	Update	
<b>[Organisational learning and culture. Baseline level of assurance – Medium]</b>				
13a. Ensure continued focus on delivery of the organisational and Divisional Improvement plans.	Gill Harris, Executive Director of Nursing and Midwifery	31/03/2021  New proposed timescale 30 June 2021	Lead amended from Sue Green to Debra Hickman. This action links to the Quality Strategy development - See action 1a	
13b. Deploy a single improvement system across the organisation	Gill Harris, Executive Director of Nursing and Midwifery	31/03/2021  New proposed timescale 30 June 2021	Lead amended from Sue Green to Debra Hickman. This action links to the Quality Strategy development- See action 1a	
<b>Recommendation 14 - The organisation has a strong approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken within the organisation and across the NHS.</b>				
Action	Lead	Deadline	Update	
<b>[Baseline level of assurance – Low/Medium]</b>				
14a. Establish clinical summits (chaired by the Executive Medical Director) with clinical	Arpan Guha, Interim Executive	31/03/2021	This work has paused due to Covid-19.	

leaders and the executive team, to review the quality of the main pathways (e.g. looking at safety, national clinical audit data, outcomes and experience measures) as a key aspect of delivering a new digitally enabled clinical strategy.	Medical Director	New proposed timescale 30 June 2021	See sections 7 and 11.  Work has restarted.	
14b. Ensure national clinical audits are explicitly embedded in the new clinical strategy and pathways – and used to benchmark the Health Board so that organisational learning can be improved.	Melanie Maxwell, Senior Associate Medical Director	31/03/2021	Pathways must identify if linked to Tier 1 mandatory audits. Clinical Effectiveness Group Quarterly review of Audit Plan to include if Pathways audits if required.	



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WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	Quality, Safety and Experience Committee 4 <sup>th</sup> May 2021						
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public						
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	Patient and Carer Experience (PCE) Report – Q4 2020/21						
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Matthew Joyes, Acting Associate Director of Quality Assurance Carolyn Owen, Head of Patient and Carer Experience Yvonne Williams, Complaints Lead Manager Jane Owen, Patient and Carer Engagement Lead Manager						
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO Matthew Joyes, Acting Associate Director of Quality Assurance						
<b>Atodiadau</b> <b>Appendices:</b>	1. Patient and Carer Experience Report – Q4 2020/21						
<b>Argymhelliad / Recommendation:</b>							
The QSE Committee is requested to note the ongoing planned improvement work, including review of various Health Board processes.							
<b>Ar gyfer penderfyniad /cymeradwyaeth</b> <b>For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth</b> <b>For Discussion</b>		<b>Ar gyfer sicrwydd</b> <b>For Assurance</b>	✓	<b>Er gwybodaeth</b> <b>For Information</b>	
<b>Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol</b> <b>Y/N to indicate whether the Equality/SED duty is applicable</b>						N	
<b>Sefyllfa / Situation:</b>							
The Quality, Safety and Experience Committee is the delegated Health Board Committee with responsibility for seeking assurance on patient and carer experience. This report provides the committee with information and analysis on significant patient safety issues arising during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway.							
<b>Cefndir / Background:</b>							
This report is designed to offer improved information and analysis in relation to patient and carer experience, in order to improve the assurance received by the committee. The period under review is primarily January to March 2021 (inclusive); however, longer-term data (allowing month on month comparison) has been included in the graphs to provide a better longitudinal view and to enable the use of statistical process control (SPC) charts.							
<b>Asesiad / Assessment &amp; Analysis</b>							
Assessment and analysis is included within the report including a breakdown of complaints and patient feedback and a high-level summary of identified learning and improvements.							

**Goblygiadau Strategol / Strategy Implications** – Not applicable.

**Opsiynau a ystyriwyd / Options considered** - Not applicable.

**Goblygiadau Ariannol / Financial Implications** – Not applicable.

**Dadansoddiad Risk / Risk Analysis** – This is contained within the report.

**Cyfreithiol a Chydymffurfiaeth / Legal and Compliance** – This is contained within the report.

**Asesiad Effaith / Impact Assessment** – Impact assessments are not required for this report.

# **Patient and Carer Experience Report Q4 2021/22**

Produced by the Patient Safety and Experience Department,  
Office of the Executive Director of Nursing and Midwifery

## 1. INTRODUCTION

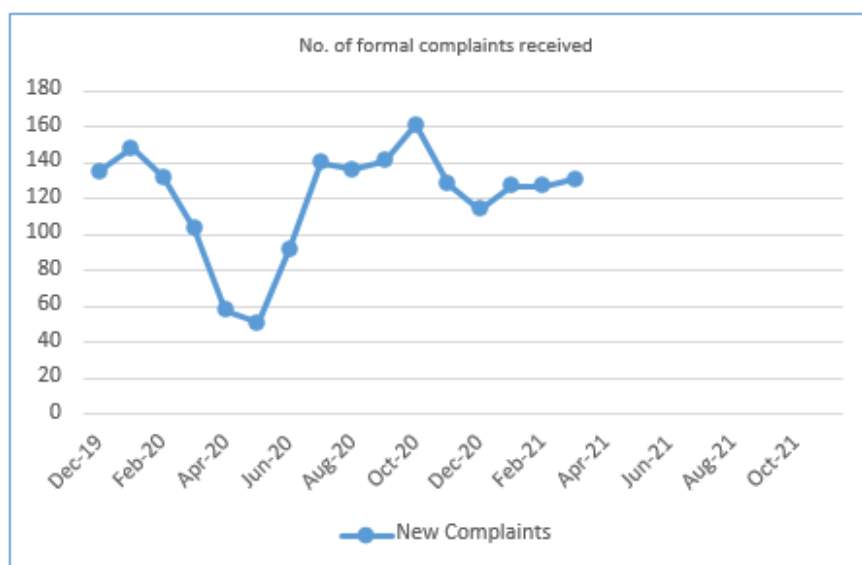
- 1.1 Patient and carer experience is what the process of receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing safe care and clinically effective care.
- 1.2 This report provides the Quality, Safety and Experience Committee with information and analysis on significant patient experience issues arising during the quarter under review, alongside longer-term trend data, and information on the improvements underway. The aim is to provide the committee with assurance on the Health Board's work to improve patient experience.
- 1.3 The Health Board has responsibilities for improving patient experience under the following key statutory responsibilities and policy frameworks;
  - NHS Delivery Framework 2019/2020 (NHS Wales, April 2019);
  - Listening and Learning from Feedback – A Framework for Assuring Service User Experience (Welsh Government, 2015);
  - Healthcare Standards for Wales (Welsh Government, 2015)
  - Wellbeing of Future Generations (Wales) Act 2014;
  - Social Services and Wellbeing (Wales) Act 2014;
  - Parliamentary Review of Health & Social Care in Wales (Welsh Assembly, 2018)
- 1.4 The Health Board approved its current Patient Experience Strategy in June 2019 and this can be accessed on its web site. The strategy is currently being reviewed to capture learning from the first year of implementation and to consider integration of wider issues such as carer engagement, involvement and support.
- 1.5 Statistical process control (SPC) charts or run charts are used where appropriate to show data in a meaningful way, differentiating between variation that is expected (common cause) and unusual (special cause). The NHS Improvement SPC Tool has been used to provide consistency throughout the report. This tool uses the following rules to highlight possible issues:
  - A data point falling outside a process limit (upper or lower) indicates something unexpected has happened as 99% of data should fall within the process limits – the process limits are indicated by dotted grey lines.
  - Two out of three data points falling near a process limit (upper or lower) represents a possible change that should not result from natural variation in the system – the process limits are indicated by dotted grey lines.
  - A run of seven or more values above or below the average (mean) line represents a shift that should not result from natural variation in the system – this is indicated by coloured dots.
  - A run of seven or more values showing continuous increase or decrease is a trend – this is indicated by coloured dots.
  - A target (if applicable) is indicated by a red dotted line.
- 1.6 For ease of reading the charts, variation icons describe the type of variation being exhibited and assurance icons describe whether the system is achieving its target (if applicable).

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

## 2. COMPLAINTS PERFORMANCE

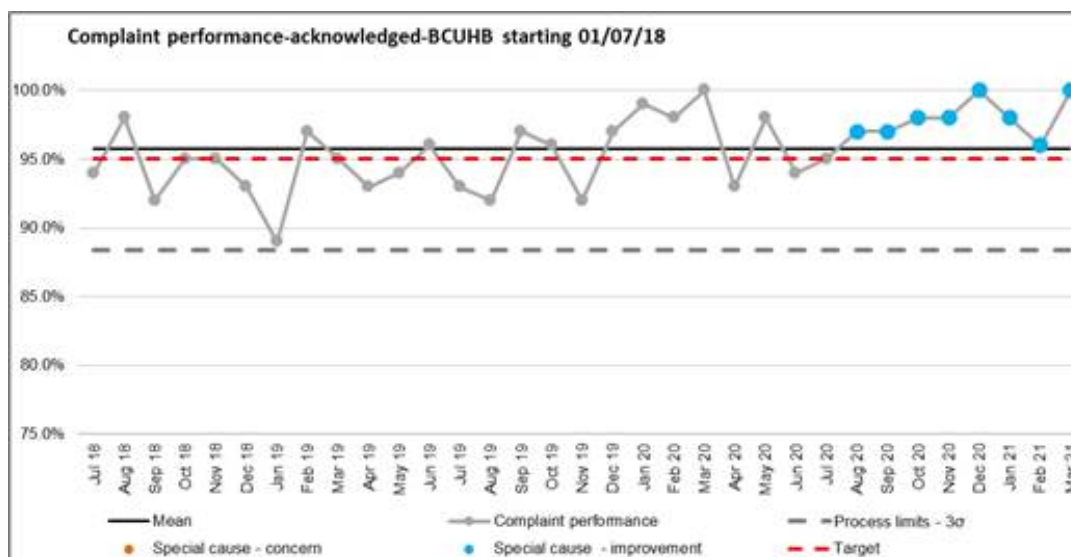
- 2.1 Complaints are received and responded to in accordance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (commonly known as Putting Things Right – PTR) and/or Health Board policy and procedure. Information is also included in this report to enable triangulation of patient safety issues arising from complaints.
- 2.2 As can be seen in Graph 1, as of the end of March 2021, the Health Board had received 385 formal complaints for Q4 taking the number back to pre-pandemic figures.

Graph 1



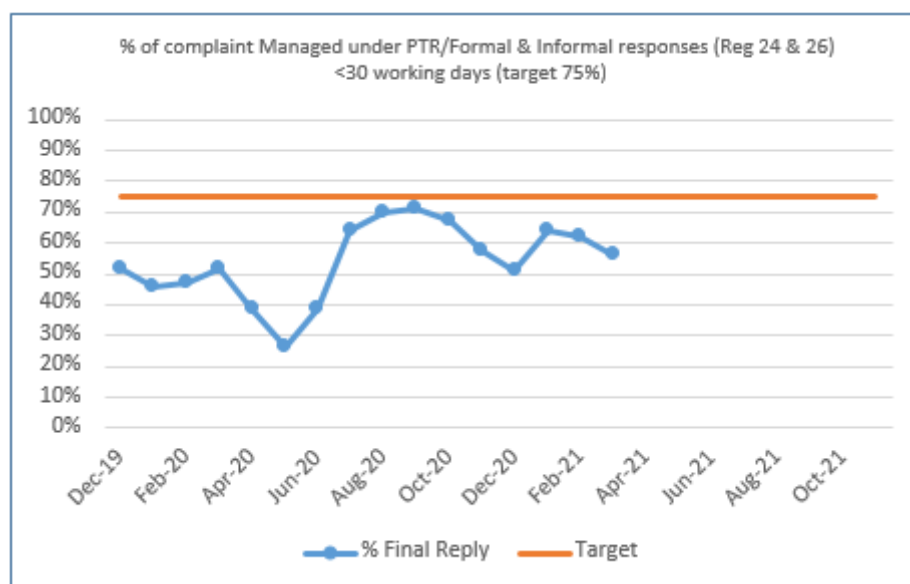
- 2.3 As can be seen in Graph 2, as at the end of March 2021, 100% of complaints were acknowledged within 2 working days against a target of 95%. This reflects an improved position and sustainably above the target. It is considered this is a direct result of the improvements made.

Graph 2



- 2.4 At the end of March 2021, performance fell below target for complaints closed within 30 working days at 60.82%, against an all Wales target of 75% (graph 3). A more in depth breakdown follows.

Graph 3



- 2.5 The 75% target for 30 day response rate is not being met by Secondary Care Teams (graph 4).

### **East Secondary Care**

East have shown a persistent downward trend in 30 day response rates with a noticeable downward trend from October 2020. In January 2021 they had a 25.0% response rate, in February a 42.86% response rate and in March a 27.27% response rate and an average of 31.71% 30 day response rate in Q4 which gives them a significant drop when compared to the response rate in Q3.



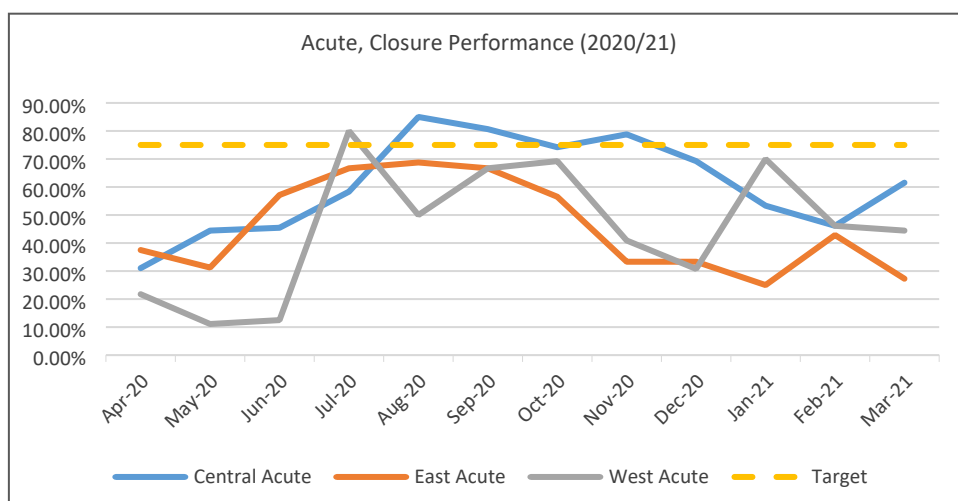
### **Central Secondary Care**

Central are also showing a significant drop in 30 day response rates since December 2020. In January they had a 53.3% response rate, in February 46.15% response rate and in March 61.54% response rate, this gives an average of 53.66% 30 day response rate in Q4 which shows a significant drop when compared to the response rate in Q3.

### **West Secondary Care**

West have had a drop in their 30 day response rate from January 2021. In January they had 70% response rate, in February 46.15% response rate and in March 44.44% response rate which gives an average of 53.53 for Q4 which is an increase compared to the response rate in Q3.

Graph 4



All sites within Secondary Care have submitted improvement plans to remedy performance, initially in terms of clearing the backlog and then in terms of addressing completion times. Additional support has been offered from the Corporate Complaints Teams. The new complaints process will also support improvement.

- 2.6 As demonstrated below in Graph 5, the 75% target for 30 day response rates are not being met by Area Teams.

### **East Area**

East Area have shown a consistent 30 day response rate with improvement in this quarter. In January 2021 they had a 62.5% response rate, in February 2021 an 81.82% response rate and in March a 67.44% response rate which gives them an average of 70% for Q4 which is an increase compared to Q3.

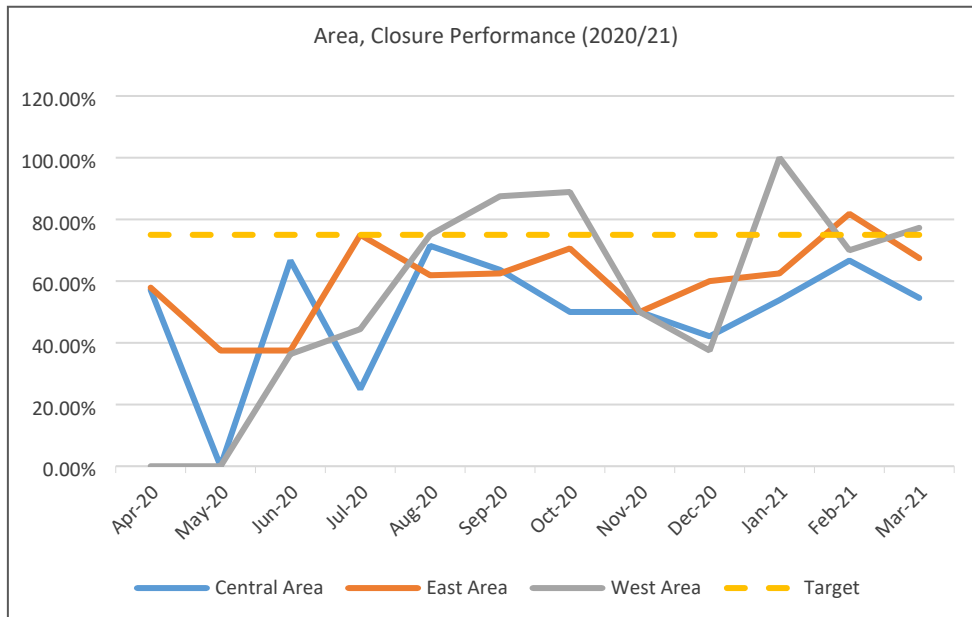
### **Central Area**

Central Area have shown an improvement in 30 day response rate in Q4 however they remain with the lowest performance. In January 2021 they had a 53.85% response rate, in February 2021 a 66.6% response rate and in March 2021 a 54.55% response rate which gives them an average of 58.33% for Q4 which is an improvement compared to Q3.

### **West Area**

West Area have a consistently improving 30 day response rate with January 2021 showing as 100%, in February 2021 a 70% response rate and in March 2021 a 77.27% response rate which gives them an average of 82.42% for Q4 which is an improvement compared to 58.79% in Q3

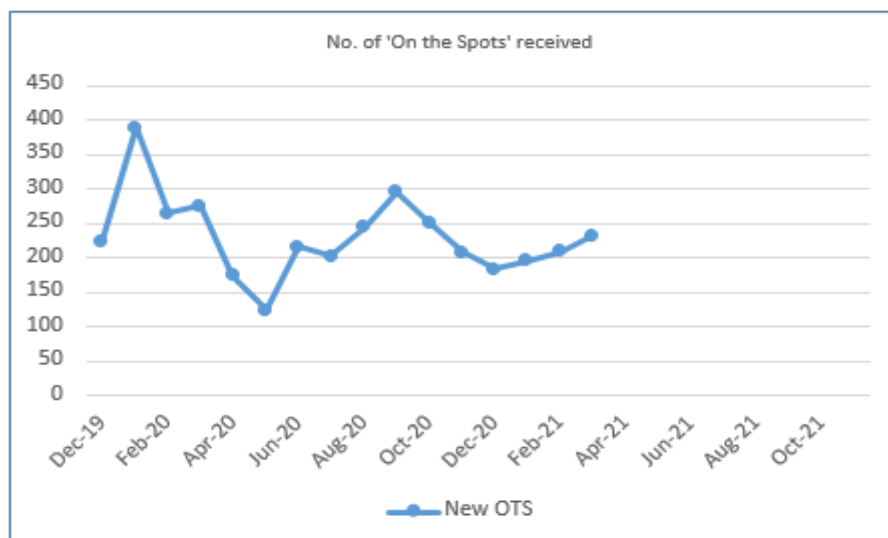
Graph 5



All Areas have submitted improvement plans to remedy performance. Additional support has been offered from the Corporate Complaints Teams. Central Area presents the area of most concern with a high number of overdue complaints. Additional resource is being recruited by the division to address this. A recurring theme contributing to the delay is the interface with independent primary care practices. The Corporate Complaints Team is progressing a meeting with the primary care teams to identify improvements. The new complaints process will also support improvement.

- 2.7 The Mental Health and Learning Disability Division has good performance at complaints response and performs well against target. The average performance over the quarter was 85.43% with an average of 5 overdue complaints.
- 2.8 As can be seen in Graph 6, during March 2021, 232 early resolution cases were recorded, of which 14 were upgraded to formal (6%). This compares to 210 cases in February, of which 31 were upgraded to formal (15%) and 196 cases in January of which 18 progressed to formal (10%).

Graph 6



- 2.9 Reasons for failure to manage within early resolution include the inability to resolve the matter within 2 working days. This may be due to difficulties in obtaining information within the 2-day timeframe. This is highlighted in primary care at present, which is an area usually successful at resolving matters promptly but currently experiencing significant difficulty in speaking with staff and obtaining prompt responses to queries due to pressures on GP practices. Other reasons are where initial enquiries establish that the issue is more complex than initially thought; this would also trigger conversion to the formal Putting Things Right (PTR) process.

### **3. COMPLAINTS LEARNING**

- 3.1 As part of the new complaints process being implemented process, the Corporate Complaints Team have also been asked to flag themes or issues of concern as they become aware. This is a daily 'whiteboard' approach, taking the opportunity to flag issues up on an ad hoc basis, in addition to the conventional reporting mechanisms.
- 3.2 The Corporate Complaints Team are evaluating alternative ways of capturing lessons learned and themes and trends. It is recognised that searches in the current Datix system are not conducive to this approach, particularly on the topic of communication. It is acknowledged that this is the highest theme of complaints but within that category it may encompass a failure to let a family know that a relative had fallen for example, or to call relatives in to a dying patient, or it could be that the tone of conversation is perceived is rude. The range of possibilities under the heading of communication does not always reflect the level of impact.
- 3.3 The new process will involve all actions arising from complaints being logged and tracked through the Datix system allowing learning and improvement work to be captured, reported and tracked.
- 3.4 As the new processes are rolled out, improved learning information can be included in this report.

### **4. NEW COMPLAINTS PROCEDURE**

- 4.1 In February 2020 the Associate Director of Quality Assurance instigated a full review and re-design of the Health Board Complaints process. Regrettably due to COVID, this was delayed with implementation of new ways of working commencing in April 2021. The aim of the complaints process review is to produce a new complaints policy, procedure, guidance and process for managing complaints. The scope of this process begins at the first contact stage and is completed when there is evidence of resolution and demonstrable learning and action. Underpinning the practical changes is a fundamental shift in approach and methodology to one that is open and focused on resolution.
- 4.2 A project structure was developed involving key clinical leads. The Patient and Carer Experience Team consulted widely on this work. External expertise was commissioned to provide independent advice to inform the review. Benchmarking on an UK wide basis was undertaken to identify best practice. This included a benchmarking exercise with Northumberland Healthcare NHS Foundation Trust – a recognised exceptional leading organisation for patient experience. An engagement event was held with the Community Health Council (CHC) to find out what matters most to patients, carers and families with the complaint process. A series of facilitated events took place involving key stakeholders.
- 4.3 A detailed update was provided earlier in the year, however in summary the new process is focused around four domains:

- First contact
- Early resolution
- Investigative quality
- Final responses

4.4 As outlined above, work is now underway to implement the new process. Additional interim resource has been confirmed to support implementation. Implementation work includes:

- Finalisation of a new policy and procedure
- New “first contact” process (formerly known as triage)
- New templates and tools for investigation
- New training for staff
- New quality assurance and moderation processes
- Clarity on handling complaint responses and redress responses

4.5 Training for the new complaints procedure commenced in January 2021 with sessions outlining the key elements of the new procedure and summarising the key changes. The sessions were delivered to staff members throughout January, February and March with more sessions scheduled over the next few months. To date, members of the Corporate Complaints Team have delivered training via Microsoft Teams to 440 members of staff. In some instances, two or three individuals have attended via the same link so numbers trained are in excess of 500 for this quarter. All staff have been urged to attend and details of the rolling training programme shared on the all user bulletin board. A targeted approach will also be taken where it is noted that key staff have not yet taken up the offer of training. The new procedure will be launched fully in May following ratification of the procedure.

4.6 The training emphasises the key changes to the way we manage complaints and emphasises the benefit of addressing matters at the stage of first contact, focussing on early resolution and robust communication at source. The training also covers the importance of scrutiny of the detail of the communication upon receipt. The procedure emphasises the importance of ascertaining whether a matter is a complaint, enquiry or opinion, in order to signpost to the most efficient route for speedy resolution. Feedback from the consultation of the new procedure along with the training sessions held to date is very positive.

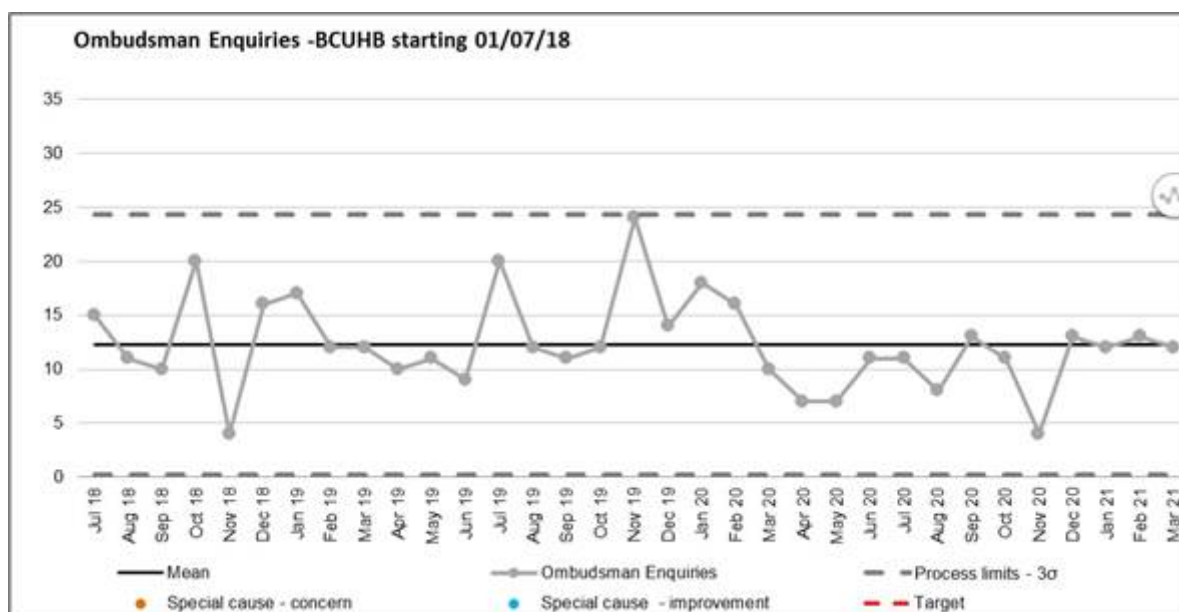
4.7 A modular training approach (a passport to training) will be taken, where staff members, depending upon their role, will be offered training for different elements of the steps in the complaint process, for example investigation training for individuals who will be undertaking the role of Investigating Officer, report writing training for those staff who will be responsible for writing reports. National training from the Ombudsman will support the in-house offer.

4.8 In support of the new complaints procedure, the Patient Advice and Liaison Service (PALS) are working more closely with the Complaints Team. A centralised call team (known as CCC) facilitates the management of telephone calls across the three sites. This system pools skills and knowledge and places less reliance on staff being based on the individual sites. This demonstrated the benefit of aligning complaints with the patient experience function.

4.9 The CCC function facilitates a “Once for North Wales” approach where initial contact, review and decision on the most appropriate steps to achieve an early resolution can be managed in one contact. This centralised approach allows for review all first contact correspondence and to enable the teams to facilitate the most effective way of enabling rapid resolution to concerns presented by patients and carers. This closer working relationship will facilitate efficient communication and sharing of knowledge of services and key contacts for signposting to swift resolution.

## 5. OMBUDSMAN

- 5.1 The Public Services Ombudsman of Wales (PSOW) has legal powers to look into complaints about public services and independent care providers in Wales.
- 5.2 During the months under review the Ombudsman contacted the Health Board regarding 37 new concerns (compared to 28 in the previous comparable period).



- 5.3 During the period under review the Health Board have received notification that a further 13 new complaints will be fully investigated by the Ombudsman, (compared to 11 in the prior comparable period).
- 5.4 The Health Board currently has 63 Ombudsman Investigations ongoing across the Health Board, of which 22 are within the West, 26 within Central and 15 within East.
- 5.5 During January 2021, the Ombudsman recognised the impact Coronavirus (COVID-19) was having again on public service. The Health Board was assured that the Ombudsman would take full account of the current context in assessing and investigating complaints, and although committed to delivering their statutory responsibilities, in no way wanted to put additional pressure on service providers during this unprecedented situation. The Ombudsman has understood that the Health Board may not have been in a position to respond to them within the usual time frames, in particular, when intending to start an investigation, as well as process early resolution proposals and stressed that they understood that resources were likely to be stretched.
- 5.6 The Public Service Ombudsman for Wales' Annual Letter was received in November 2020 (Appendix i). This was due to be presented to the Board via the Quality, Safety and Experience (QSE) Committee on 3 November 2020, but with meetings being postponed is being presented at the April 2021 meeting. The Health Board responded to the Ombudsman's Annual Letter on the 10<sup>th</sup> November (Appendix ii) outlining the ongoing improvements.
- 5.7 Members of the Patient and Carer Experience Team have met with the Ombudsman's Complaints Standards Authority Team to discuss the development of a skills pathway and training passport for those involved in managing or investigating complaints and have also accepted the offer of free complaints training which is due to take place during April 2021. One session will be related to Handling Complaints & Negotiating and the other on Complaint Investigation Skills. The training is designed to support and enhance complaint handling

throughout public services by considering best practice from multiple sectors from around the world.

- 5.8 An Ombudsman Procedure has been drafted for ratification at the Patient and Carer Experience Group. This procedure sets out the requirements under the Public Services Ombudsman (Wales) Act 2019 for the management of and learning from Public Services Ombudsman for Wales investigations of concerns. A period of consultation has been carried out to include the Public Services Ombudsman for Wales, Health Board senior clinical staff, Governance Teams as well as the Community Health Council.
- 5.9 Quarterly calendar dates have now been scheduled with the Ombudsman's Improvement Officer to promote partnership working with the Ombudsman's office. The Health Board's contact officer has remained in regular contact during the pandemic. The Health Board met the Ombudsman's Improvement Officer on 21<sup>st</sup> January 2021 with further regular meetings arranged.
- 5.10 During March 2021, the Ombudsman's Thematic Report was received. One of the recommendations was to ensure that public services take up the offer of complaints handling training from the Complaints Standards team.

## **Emerging**

## **Themes**

Within the Central area, four Ombudsman Investigations are related to the Emergency Department (ED), three of which are stroke related:

- a) Health Board failed to carry out a video fluoroscopy and barium swallow in a timely manner with a failure to recognise a deteriorating condition in general, which potentially caused, or contributed to, a later bleed on the brain.
- b) Failure to report on an X-ray taken which delayed appropriate medical management, which resulted in a further ED admission. The complainant believes that had his wife been admitted to hospital for further investigations, the lung cancer and brain metastases would have been diagnosed sooner and his wife would have received treatment that would have prevented her stroke.
- c) Following an emergency admission with an ischaemic stroke, Emergent Department clinicians failed to administer appropriate thrombolytic medication within the stipulated timeframe. The delay in receiving this medication resulted in the patient suffering severe physical and cognitive deterioration.
- d) Missed opportunities to diagnose and treat a stroke at an earlier stage following admission to ED.

Another emerging theme is the increased number of cases being returned to the Health Board by the Ombudsman with instruction that they are to be re-investigated under the Putting Things Right Regulations in order to consider Redress. This is due to the poor quality and inadequate initial investigation held by the Health Board where qualifying liability has not been considered. There are 7 cases which the Ombudsman has recommended they be considered for Redress, 2 cases to be investigated by the Ombudsman are COVID-19 related. The new complaints process and associated training will address these issues.

## **7. COMMUNITY HEALTH COUNCIL**

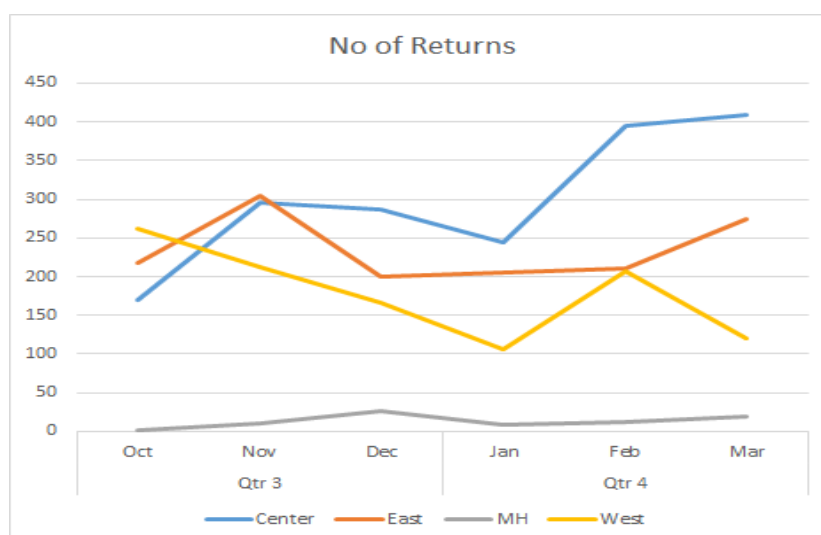
- 7.1 North Wales Community Health Council (NWCHC) continues to suspend their review programme and routine inspections due to restrictions resulting from COVID-19.

- 7.2 They are currently focussing on engagement activities and continuing to support service users with provision of the advocacy service for complaints.

## 8. PATIENT FEEDBACK

- 8.1 Patient feedback not only supports the Health Board to understand the feelings and views of patients, carers, and service users, it also provides a learning platform for service improvements. To ensure all areas are compliant with capturing 20% experience feedback, which is a key performance indicator within the Patient and Service User Experience Strategy, the Patient and Carers Experience Team actively support all services to ensure that opportunity is taken to capture feedback. Whilst the View Point System ended in February 2020. Prior to the introduction of the new CIVICA system, the Patient Experience Team have continued to seek service user feedback through various means, including paper questionnaires, increased media visibility, and a bilingual PALS phone line, and inbox. We have also introduced a fully accessible, service user questionnaire to the intranet, with return rates for Q4 indicating a rise on previous quarters. This is encouraging, as it not only demonstrates engagement by those using our services, it also highlights a willingness by service leads to hear those experiences, with managers actively seeking the QR codes for this tool, and displaying them in their service areas, an example being Wrexham Maelor ED.

	Centre	East	West	MH	Tot
<b>Qtr 3</b>					
Oct 2020	169	217	262	1	649
Nov 2020	296	305	213	11	825
Dec 2020	287	200	167	27	681
<b>Qtr 4</b>					
Jan 2021	245	205	106	9	565
Feb 2021	395	210	207	12	824
Mar 2021	410	275	121	20	826
<b>Total</b>	<b>1802</b>	<b>1412</b>	<b>1076</b>	<b>80</b>	<b>4370</b>



- 8.2 The value of feedback is unquestionable, in that it can guide, and drive service delivery improvement. The need to demonstrate the learning, along with assurance that it has been embedded into practice, remains as crucial as the feedback itself. A mechanism which will support in this assurance is the new complaints procedure, whereby any complaints which have received a comprehensive investigation, will have to be signed off by a senior service manager for that particular area offering assurance that any learning has been recognised,

implemented, and will be monitored. The final step being key, as it will prevent recurrence of themes in that area, and offer reassurance to those affected.

- 8.3 Not all feedback is negative, and there are many examples of excellent care brought to our attention by our patients and their families. The celebration, and dissemination of positive practice, is as crucial as negative experience, as it not only shares innovation, but also raises staff morale. The Patient Experience team select a 'Friday Feel-good Comment of the Week' with a certificate being presented to the individual unit, then publicised on the Health Board's social media pages. The ability to utilise patient feedback to increase staff motivation, well-being and job satisfaction is an extremely important consideration for BCUHB.

Examples of Feel Good Friday comments received in Quarter 4:

"Medical staff on DOSA Escalation ward were fantastic, they kept us updated every step of the way. My son and I were both Covid-19 positive so could not visit the ward but at 4am a nurse called Beth telephoned to say that our relative was passing and that she would hold his hand to comfort him."

'This is a long overdue thank you to everyone at Ysbyty Gwynedd for the outstanding care that my mother received-she could not have had better care. Welsh speaking made her feel especially at ease. We continue to live through extraordinarily difficult times. Please know that your skills, your care and all the little kindnesses matter more than words can express. Thank you all.'

- 8.4 There are always areas in care, where improvements can be made in relation to patient, carer, and service user feedback. In the quarter under review, the two top, consistent themes, received across all areas within the Health Board are:-
- Communication is a broad area, and the range of problems encountered is at times complex. It would be fair to suggest that during this time scale, the major problem encountered is families accessing information from clinical areas about their loved ones. This has heightened by the ongoing visiting restrictions. There has also been concerns about the lack of information being offered to relatives about the care and treatment of their relatives, again heightened by lack of physical visiting.
  - Co-ordination of Care is the next consistently high theme which is again being feedback across all areas of the Health Board. The title in itself, does not perhaps clarify the difficulties being experienced, but many situations are directly linked to ineffective communication regarding the care, treatment, plans and location of relatives.
- 8.5 In response to the problems related to communication, there have been efforts within service areas to address these issues, with the possible introduction of twenty four hour ward clerks, to the delegation of update to the patient experience teams who are willing to support. The Patient Experience Team have also taken over IPAD distribution, and house the devices in the hubs, within acute sites. We are currently requesting that all older IPADs be returned to our hubs in order that they may be updated. The recall of these devices has been slow, and whilst this may indicate that they are being actively used, we would appreciate this knowledge.
- 8.6 The following feedback has been collected within the last quarter, and passed on to the relevant services so that changes can be made



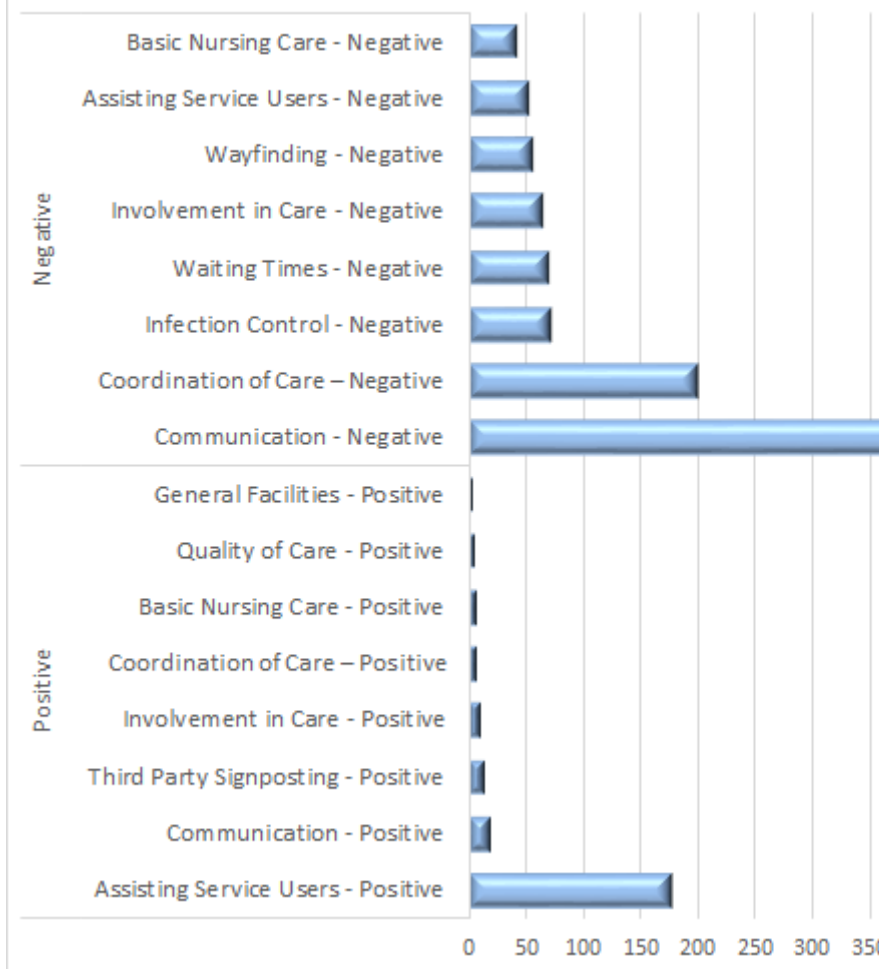
**Qtr 4 – 2020/2021  
– PALS Enquiries  
Sub Themes**

<b>Positive</b>	<b>242</b>
Assisting Service Users - Positive	177
Communication - Positive	19
Third Party Signposting - Positive	13
Involvement in Care - Positive	11
Coordination of Care – Positive	7
Basic Nursing Care - Positive	6
Quality of Care - Positive	5
General Facilities - Positive	4

<b>Negative</b>	<b>937</b>
Communication - Negative	381
Coordination of Care – Negative	199
Infection Control - Negative	71
Waiting Times - Negative	70
Involvement in Care - Negative	65
Wayfinding - Negative	56
Assisting Service Users - Negative	53
Basic Nursing Care - Negative	42

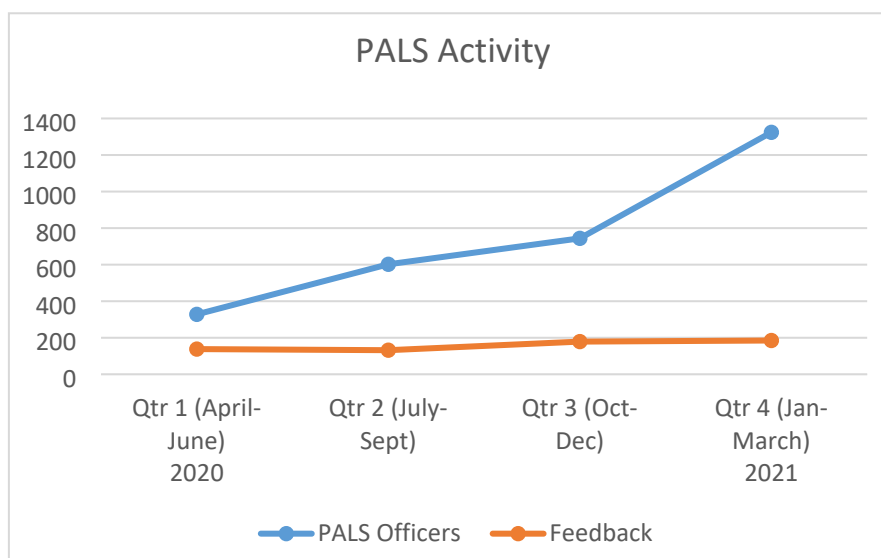
**Total 1,179**

**PALS Enquiries Top 8 Sub-Themes**



**PALS Activity Relating to Covid 19 Immunisation Programme  
January – March 2021**

There has been a significant rise of almost 50% in the cumulative activity of the PALS teams from Q3 – Q4. This is indicative of the high number of enquiries pertaining to communication issues, and the associated co-ordination of care.

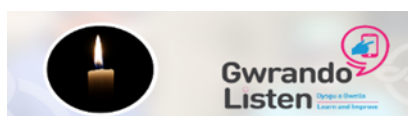


Recently, the introduction of the immunisation programme has led to a surge of enquires by those anxious to know when they will receive theirs. In response to this, the team are collaborating with the COVID vaccination co-ordinators, to ensure enquiries are resolved as quickly as possible.

## 9 PATIENT STORIES

- 9.1 Stories told by individuals from their own perspective in a health care setting can provide an opportunity to understand their lived experience of the care received. This is a powerful method of collecting patient feedback and can identify opportunities for service improvement. The existing procedure has been sent out for consultation, and will be presented at the PCE Group. Once ratified training will be offered across all areas to enable individual to gather both staff and patient stories in a quality assured format. The digital story work stream is progressing well, with voice recorders being purchased, and used in a number of cases, with extensive training received by two PALS officers, to be cascaded. Video equipment has also been procured, along with training for the whole team with a local production company.

## 10 PATIENT EXPERIENCE BEREAVEMENT AND LIAISON SUPPORT

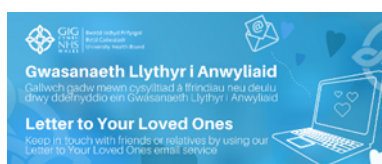


As a consequence of the COVID-19 pandemic Patient and Service User Experience have embraced new ways of working, below are positive examples developed:

- 10.1 During the continuing COVID-19 pandemic, it remains possible that the volume of families BCUHB Bereavement Officers will be supporting, could increase. To support this service, the Patient Experience Team, in partnership with existing services, developed a 'bereavement and liaison support service', its aim being to listen, offer advice and support. Whilst the creation of this service, was in response to a potential crisis, a positive taken from this co-working, is that without doubt co-production of series has increased, along with a far greater understanding of where we all sit, and at times overlap with each other. Standing membership on the Quality Bereavement Group enables cohesive service delivery planning, and the offer of a high quality service to those who are bereaved. We as a group are currently scoping bereavement models to provide a framework and standardised approach across the Health Board.

- 10.2 Following a successful funding application to Awyr Las, and initial scoping for bereavement gardens, it was decided that throughout the health board, a wide range of reflective spaces were already in existence. Consultation took place with the Health Boards arts therapist, and it has been decided, that artwork is to be commissioned across acute and community sites, which will incorporate the 'hearts' produced by Awr Las volunteers. A commemorative book outlining the pandemic, has also been commissioned, and will include photographs of staff, poetry, stories, and recollections. Our aim is that we can not only remember this period in time, but also continue to produce funds through the sale of this book, to support those affected by the pandemic. The final portion of the monies from Awr Las are being used to buy mobile IPAD stands, to enable those who are too weak to hold the devices to communicate privately with their loved ones.

## 11 LETTERS TO LOVED ONES



- 11.1 During the COVID-19, visitors to hospitals have been restricted; Letters to Loved Ones has been developed to maintain communication between loved ones and patients.
- 11.2 A message can be sent via email or passed over the phone that message will then be delivered to the patient on the wards. This remains a popular service, with the restrictions on visiting remaining in place. Over the last quarter there have been 2911 views.
- 11.3 Letters to Loved Ones received over Q4 2021/22
- Centre 108
  - East 108
  - West 57

**The following feedback was received:**

*'Many thanks for your reply. Especially in these times, this is a terrific service and very much appreciated.'*

## 12 CARERS STRATEGY

- 12.1 The Carers Strategy now sits operationally within the Patient Safety and Experience Team. The Patient Experience team fully recognise the challenges that carers normally face, these being exacerbated by COVID-19. In response, the carers strategy is being developed, along with an action plan, at pace, along with an alignment process being underway with existing services.
- 12.2 The work for carers continues at pace, with extensive links being forged between the existing carers agencies, and the Patient Experience Leads; membership being gained on many Carers groups, including both statutory agencies and specialist services such as dementia care.

## 14. PATIENT & CARER CHAMPIONS

- 14.1 Following a successful recruitment campaign, which remains ongoing, we have launched this exciting initiative. Induction sessions are ongoing, and being positively received, with the range of those who have volunteered being diverse. This is what we as a team were aiming for, as this will help to ensure that all services have that designated person, who has shown a willingness to promote and maintain the Patient Experience and Carer agenda. The leads have

also established links with Bangor University to link in with the student population, in a range of health professions, to become roving Champions.

## **15 ACCESSIBLE HEALTH CARE**

- 15.1 Following the return and analysis of the accessible health care audit, our next stage was to carry out spot checks in areas to gain that extra assurance that awareness of these tools existed. Following a successful meeting with the Quality Improvement team, our shared aim is to add to additional questions into the ward accreditation scheme, to highlight both good practice, and possible training needs.
- 15.2 The Patient and Carer Experience Team have also joined mental health services, to explore accessibility to mental health services, for those with hearing loss. We are still in the scoping phase, but will update this meeting when possible.

## **16. CONCLUSION AND RECOMMENDATIONS**

- 16.1 This report aims to provide the Quality, Safety and Experience Committee with information and analysis regarding significant patient experience issues arising during the quarter under review, alongside information on the improvements underway. The aim being to provide the committee with assurance on the Health Board's work to improve patient experience.
- 16.2 The QSE Committee is requested to note the ongoing planned improvement work, including review of various Health Board processes.



Date: 30 November 2020

Gill Harris  
Betsi Cadwaladr University Health Board

By Email only

Dear Gill

The Public Services Ombudsman (Wales) Act 2019 achieved Royal Assent in July 2019. The world has changed considerably since then, in response to the COVID-19 pandemic. We have aimed to support Public Bodies during this unprecedented time. We are now re-engaging with Health Boards to take forward aspects of our new powers.

My Complaints Standards Authority, led by Matthew Harris, our Head of Complaints Standards, has engaged widely with representatives from Public Bodies in the last year. The Team has met with committed staff, all of whom understand the impact that considerate complaint handling and administration can have on the outcomes experienced by the people of Wales. Our visits last year, and more recent virtual meetings, have started a new conversation about complaint handling standards, allowed us to take stock of existing good practice and enabled us to explain our offer of bespoke training.

Now that Complaints Standards work with Local Authorities is more established, it is right that we extend our reach to Health Boards. The decision to move forward with this work in the current climate has not been taken lightly and has been made with significant input from the Health Boards and Welsh Government. We anticipate that the introduction of our Guidance will lead to minimal additional demand on your teams whilst allowing us to provide you with additional support in the form of our training.

The training – which will be delivered at no charge – is designed to support and enhance complaint handling throughout public services by considering best practice from multiple sectors from around the world. We will work with public

bodies to ensure that the training we deliver is personalised to each service, incorporating elements of their own systems where necessary and considering the audience for each session.

These ground-breaking sessions began with Local Authorities in September – via a new virtual approach which remains true to our interactive plan. Training sessions will be available for Health Boards from February 2021, and the Complaints Standards Authority will be in touch shortly to make further arrangements.

Since July last year, we have also received quarterly complaints data from public bodies – the first time this has happened in Wales. This data allows new insights into the way public bodies record and handle complaints and gives fresh context to our current data. The new 'Once For Wales' system will allow Boards to capture the required data consistently, which will ultimately be published on our website and inform the way our annual letters and reports are framed.

Our Statement of Principles, Model Complaint Handling Process, and Guidance will now apply to Betsi Cadwaladr University Health Board, and copies can be found on our website – [www.ombudsman.wales/complaints-standards-authority](http://www.ombudsman.wales/complaints-standards-authority).

Therefore, and in compliance with Section 38 of the new Act, I would actively encourage all public bodies to reflect on how their own practices and procedures comply with the stated guidance and consider how they will ensure that all complaints are captured appropriately.

In accordance with the Act, I must receive a copy of your updated complaints handling procedure within six months of the date of this letter.

I would encourage you and your teams to engage with the Complaints Standards Authority should they have any questions, and I look forward to continuing working together to drive the improvement of public services in Wales.

Yours sincerely,



**Nick Bennett**  
Ombudsman

cc.Mark Polin, Chair of Betsi Cadwaladr University Health Board



Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

Appendix ii

Bloc 5, Llys Carlton, Parc Busnes Llanellwy,  
Llanellwy, LL17 0JG

Block 5, Carlton Court, St Asaph Business  
Park, St Asaph, LL17 0JG

Mr Nick Bennett  
Public Services Ombudsman for Wales  
1 Ffordd yr Hen Gae  
PENCOED  
Cardiff  
CF35 5LJ

Dear Mr Bennett,

### **Annual Letter 2019/20**

Thank you for your Annual Letter (2019/20) for Betsi Cadwaladr University Health Board dated 7<sup>th</sup> September 2020. The Health Board's senior team and Quality, Safety and Experience Committee have carefully considered your letter.

As you know, the Health Board is committed to working closely with you and your officers to ensure we listen, act and learn from complaints and I am pleased to hear in your letter of our continued positive working relationship. I note the actions for the Health Board to take and would like to update you on our considerations and proposed actions against each as requested:

#### **1. Present the Annual Letter to the Board to assist Board Members in their scrutiny of the Board's performance**

The Annual Letter has been presented to the Board via the Quality, Safety and Experience (QSE) Committee on 3<sup>rd</sup> November 2020, to assist the Board Members in their scrutiny. I am grateful for the information presented in your Annual Letter, which assists in monitoring performance of complaints management within the Health Board.

#### **2. Continue to work to reduce the number of cases which require intervention by the PSOW office**

The Health Board is continuously striving to improve our complaints management and, through this, we anticipate that the number of cases, which require intervention by your office, will be reduced. There is a programme of improvement in place to manage complaints in real-time, which includes:

- Continued focus and scrutiny on the timely resolution of complaints – during 2020 we have seen our response times to complaints improve significantly.
- Better integration of our Patient Advice and Liaison Service (PALS) alongside our Complaints Team to improve support to patients and carers and seek rapid resolution to concerns.

- Implementation of structure changes and new technology to the Complaints Team including the development of a new, virtual concerns contact centre (CCC) introduced in March 2020 and which is now a centralised point for all concerns and queries.
- Introduction of a new principles based complaints process following a full review undertaken during 2020 (in coproduction with all those involved in the complaints process including the Community Health Council), which is planned for implementation in January 2021.

In addition, there is a programme aimed at improving the quality of complaint investigations and letters alongside the new process, which includes:

- Dedicated training lead to support roll-out of the new process for the first several months.
- Development of a skills pathway and passport for those involved in managing or investigating complaints – this will link into the training offer from your Complaints Standards Authority Team who we are grateful for meeting with us twice this year.
- New templates, tools and guidance documentation for those investigating and managing complaints.
- A dedicated senior lead focusing on the quality of, and learning from, complaint investigations.

### **3. Work with the PSOW improvement officer to improve complaint handling practice and standardise complaints data recording**

I can confirm that Ms Lucy Reid, Vice Chair of the Health Board and Matthew Joyes, Acting Associate Director of Quality Assurance, met with Mrs Llinos Lake, PSOW Improvement Officer on 24<sup>th</sup> February 2020. We had scheduled in our diaries regular quarterly meetings with Llinos to ensure we maintain the good working relationship with your office, however unfortunately it has proved difficult to meet over the past few months due to the ongoing COVID-19 pandemic. Our contact officer within the Health Board, Mrs Denise Williams, remained in regular contact during the first wave of the pandemic. I am pleased these regular meetings have been reinstated and Matthew Joyes and Denise Williams met with Llinos Lake on 29<sup>th</sup> October 2020 with further regular meetings now arranged.

I trust my letter has given you assurance in response to the actions you have asked us to take. As always, we value and appreciate the strong relationship with your office and look forward to continuing this to the benefit of our patients and carers.

Yours sincerely



**Mark Polin OBE QPM**  
**Cadeirydd / Chairman**



<b>Cyfarfod a dyddiad: Meeting and date:</b>	Quality, Safety and Experience Committee 4 <sup>th</sup> May 2021						
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public						
<b>Teitl yr Adroddiad Report Title:</b>	Patient Safety Report – Q4 2020/21						
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
<b>Awdur yr Adroddiad Report Author:</b>	Matthew Joyes, Acting Associate Director of Quality Assurance Kath Clarke, Head of Patient Safety Sarah Musgrave, Incidents Lead Manager Shan Kennedy, Redress and Claims Lead Manager Debbie Kumwenda, Inquests Lead Manager						
<b>Craffu blaenorol: Prior Scrutiny:</b>	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO Matthew Joyes, Acting Associate Director of Quality Assurance						
<b>Atodiadau Appendices:</b>	1. Patient Safety Report – Q4 2020/21						
<b>Argymhelliad / Recommendation:</b>							
The Quality, Safety and Experience Committee is asked to:  1. Note the report. 2. Note the focus on improving learning, reducing incidents resulting in avoidable harm and the evolving improvement of assurance in this area recognising significant work remains. 3. Note the delay of the Once for Wales Concerns Management System. 4. Receive this report and provide feedback on its evolving content and layout.							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>	✓	<b>Er gwybodaeth For Information</b>	
<b>Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable</b>						N	
<b>Sefyllfa / Situation:</b>							
The Quality, Safety and Experience Committee is the delegated Health Board Committee with responsibility for seeking assurance on patient safety. This report provides the Committee with information and analysis on significant patient safety issues arising during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway.							
<b>Cefndir / Background:</b>							
This report is designed to offer improved information and analysis in relation to patient safety, in order to improve the assurance received by the Committee. The period under review is primarily January to							

March 2021 (inclusive); however, longer-term data (allowing month on month comparison) has been included in the graphs to provide a better longitudinal view and to enable the use of statistical process control (SPC) charts.

#### **Asesiad / Assessment & Analysis**

Assessment and analysis is included within the report including a breakdown of incidents by division/site, details of the most common type of reported serious incidents and a high-level summary of identified learning.

**Goblygiadau Strategol / Strategy Implications** – Not applicable.

**Opsionau a ystyriwyd / Options considered** - Not applicable.

**Goblygiadau Ariannol / Financial Implications** – Not applicable.

**Dadansoddiad Risk / Risk Analysis** – This is contained within the report.

**Cyfreithiol a Chydymffurfiaeth / Legal and Compliance** – This is contained within the report.

**Asesiad Effaith / Impact Assessment** – Impact assessments are not required for this report.

# Patient Safety Report Q4 2020/21

Produced by the Patient Safety and Experience Department,  
Office of the Executive Director of Nursing and Midwifery

## INTRODUCTION

Patient safety is focused on the prevention of harm to patients by improving the way in which care is delivered so that errors are prevented, learning occurs from the errors that do occur and a culture of safety is fostered that involves health care professionals, partner organisations, patients and their carers/families.

This report provides the Quality, Safety and Experience Committee with information and analysis on significant patient safety issues arising during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway. The aim is to provide the committee with assurance on the Health Board's work to improve patient safety.

Statistical process control (SPC) charts or run charts are used where appropriate to show data in a meaningful way, differentiating between variation that is expected (common cause) and unusual (special cause). The NHS Improvement SPC Tool has been used to provide consistency throughout the report. This tool uses the following rules to highlight possible issues:

- A data point falling outside a process limit (upper or lower) indicates something unexpected has happened as 99% of data should fall within the process limits – the process limits are indicated by dotted grey lines.
- Two out of three data points falling near a process limit (upper or lower) represents a possible change that should not result from natural variation in the system – the process limits are indicated by dotted grey lines.
- A run of seven or more values above or below the average (mean) line represents a shift that should not result from natural variation in the system – this is indicated by coloured dots.
- A run of seven or more values showing continuous increase or decrease is a trend – this is indicated by coloured dots.
- A target (if applicable) is indicated by a red dotted line.

For ease of reading the charts, variation icons describe the type of variation being exhibited and assurance icons describe whether the system is achieving its target (if applicable).

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

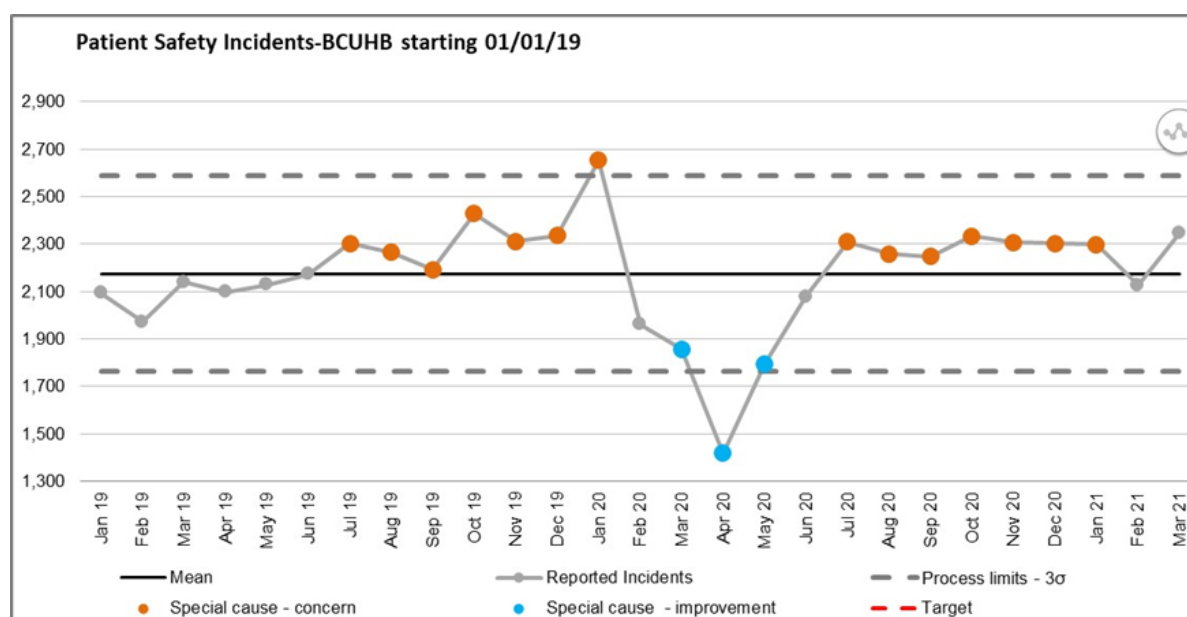
There are two sections of this report that may include incidents that affect employees and members of the public, as well as patients; these are serious incidents and liability claims. As the Patient Safety and Experience Department manage these matters, they are included in this report to provide an overall view of these areas; however, relevant information is also included in the Occupational Health and Safety Report.

During the period under review, the second wave of COVID-19 was the primary focus of the organisation and a number of measures were put in place to support this including redeployment of some governance staff and reduction in some governance processes. A further impact is that a number of serious incidents are now overdue as a result of conflicting pressures during the quarter. This has caused an impact on the production of this report in particular the analysis sections.

## PATIENT SAFETY INCIDENTS

Patient safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patients receiving healthcare. Incidents are reported on Datix, the integrated risk and safety management system used by the Health Board.

The graph below demonstrates the number of patient safety incidents reported during Quarter 4. In total, 6,769 patient safety incidents were reported in this period. The number of incidents reported has shown a very slight decrease for this quarter. In addition, the reporting of COVID-19 patient related incidents account for 610 incidents compared to 511 last quarter which reflects the increased number of patients hospitalised with COVID-19 – these include 53 relating to COVID-19 cluster outbreaks and 39 relating to inappropriate transfer.



The number of new major and catastrophic incidents reported in Q4 (n=320) has increased only very slightly from Q3 (n=315). Approximately 48% of the Datix raised as “major” relate to staff incidents (n=137), 61% of which detail staff with a positive Covid test (n=84).

The total number of “catastrophic” patient related incidents reported during Q4 is 46. The table below show the top 10 incidents by detail. It is worth noting that despite the outbreak of Covid-19 at Ysbyty Gwynedd and this being a period of time where the incidence of nosocomial infections was high, a total number of four Datix have been raised across the Health Board. This appears low and may suggest that some deaths due to hospital acquired Covid have not been recorded on the Datix system. In order to verify this the number of deaths due to hospital acquired covid reported by Infection Prevention team will be compared to the number of Datix and reported in Q1.

Nosocomial outbreaks of COVID-19 are reported to the Welsh Government (WG) directly from the Infection Prevention Team in line with WG requirements.

An extensive piece of work is now underway to map all definite and probable (as per Public Health Wales definitions) healthcare acquired COVID infections cross reference to the various investigation processes. A further update on this work will be provided in Q1. This work is in line with the recently issued (March 2021) national framework and the work of other health boards.

Q4 Incidents reported as CATASTROPHIC - Detail (TOP 10)	BCUHB Central	BCUHB East	BCUHB West	Total
Self harm in primary care, or not during 24-hour care	3	1	4	8
Diagnosis - other	1	2	1	4
Infection control	1	2	1	4
Treatment, procedure - other	0	0	3	3
Accident caused by some other means	1	1	1	3
Possible delay or failure to Monitor	1	2	0	3
Abuse etc of patient by patient	1	1	1	3
Implementation of care or ongoing monitoring - other	1	0	1	2
Slips, trips, falls and collisions	0	1	1	2
Scans / X-ray images	0	0	1	1
Total	9	10	14	33

The total number of “major” patient related incidents reported during Q4 is 100. The table below show the top 10 by detail. The figures below again suggest that across the three regions, the way in which nosocomial COVID 19 infections were recorded on the Datix system varied. It would appear from the data that East is an outlier in terms of “ Exposure to...infection” with 17 Datix reported as “ major”. Further exploration of these incidents illustrates that these incidents are related to patients that tested positive during an outbreak. In contrast, West has not recorded any Datix in this category as major. It has become evident that there is variation in processes and inconsistencies in reporting across the Health Board with some sites (Ysbyty Gwynedd) reporting an outbreak and listing each patient as a contact within that Datix, whereas other sites (for example Wrexham Maelor) record a Datix incident report for each patient affected. A standardised approach will be cascaded across the organisation, utilising the governance teams attached to individual divisions.

Q4 Incidents reported as MAJOR – Detail (TOP 10)	BCUHB Central	BCUHB East	BCUHB West	Total
Slips, trips, falls and collisions	6	13	5	24
Exposure to electricity, hazardous substance, infection etc	2	17	0	19
Pressure sore / decubitus ulcer	1	2	6	9
Infection control	5	2	1	8
Possible delay or failure to Monitor	0	2	2	4
Diagnosis - other	0	2	2	4
Implementation of care or ongoing monitoring - other	1	3	0	4
Cancer - Dx failed or delayed	3	0	0	3
Accident caused by some other means	1	2	0	3
Appointment, Admission, Transfer, Discharge - other	1	2	0	3
Total	20	45	16	81

Daily Corporate Incident Review Meetings which began in early December 2020 continue to have good attendance and are well received. They are an opportunity for Governance Leads across the Health Board to meet on a daily basis. It has become a welcome forum for advice and discussion. The Corporate Patient Safety Team have introduced the “Daily Quality Alert” which is circulated to the executives and other senior leaders following the daily meeting and highlight any serious incidents from the previous 24 hours.

## LEARNING FROM SERIOUS INCIDENTS

A number of learning points have been identified from serious incident investigations which are detailed below. Action plans are in place for each review.

Inc Number	Location	Description	Lessons Learned
Inc236983	Wrexham Maelor Emergency Department (ED)	Patient found unresponsive in waiting room	Triage and streaming are discrete functions. Patients in waiting room should be monitored prior to being seen by clinician.
Inc250365	Wrexham, Bonney Ward	Patient on Continuous positive airway pressure (CPAP) , found deceased with oxygen disconnected from mask	Tag in, tag out nursing introduced. Further incident found no tag in/tag out in operation for this patient based on risk assessment.
Inc 258713	Wrexham Maelor, ED	Electro Cardiogram (ECG) carried out. Not reviewed for 5 hours – identified silent myocardial infarction (MI)	Importance of prompt review of ECG.

Inc Number	Location	Description	Lessons Learned
Inc255741	Central Area Primary Care	Late diagnosis of 9 year old Type 1 Diabetes	All Wales Guideline for recognising and diagnosing children with diabetes not followed.
Inc255446	Wrexham Maelor ED	Patient presented following fall. CT (computed tomography) head showed bilateral subdurals. No abnormality detected (NAD) in medical record and patient sent home. Represented with further agitation when CT scan report re-reviewed.	This incident was closed without robust investigation. IT was identified through the increased corporate scrutiny and an investigation is now underway with an investigator from a different division.

Learning is shared across the organisation through governance meetings and in the case of urgent learning, through Safety Solution Leads as part of the Safety Alert Process. The new incident management process will strengthen our methodology for disseminating lessons from concerns across the organisation including a new lessons learned library, bulletin and monthly events.

### Infection Control

The Safe Clean Care campaign is being re-launched with the aim of a zero tolerance to avoidable infections. The approach being taken includes the following areas:

- Raise the focus – Enhance targeted communications campaign to share simple clear messages.
- People – Training in a clear and simple way to do the right thing, improvement skills on the ground supporting behavioural change.
- Process – Simple, easy to understand governance, plans, processes, step guides and guidelines that are in line with current good practice.
- Practice – Supporting good habits, setting things up to reinforce infection prevention behaviour.
- Performance – Agreed measures of success that align to the above, clear accountability and line of sight from Board to care giving, aligned governance and assurance.
- Praise – Strength based approach, understand what is good, what has gone well, foster pride, and share widely.

A weekly steering group is in place underpinned by key work-streams. Additional information will be provided in the Infection Prevention Control (IPC) Report.



## Falls

Falls has been identified as an emerging theme within the current context of COVID. In response, the Strategic Falls Group has been re-established with the inaugural meeting being held on 25th February 2021. The group is responsible for overseeing the reduction of falls resulting in harm across acute and community hospitals. The remit of the group is to drive improvement in the prevention and management of inpatient falls.

The Strategic Community Falls Prevention Group has also held an inaugural meeting. The Group will help inform each of the Local Community Falls Groups which are multi-professional groups led by the Community Falls Co-ordinators with representatives both internal and external to the Health Board. The Strategic Community Falls Prevention Group are developing a strategic work plan focussing on several key issues including; review of falls risk assessment tools, training plan/pack for Care Homes and first response, working with Welsh Ambulance Services NHS Trust (WAST) to manage patients in situ rather than admitting them to hospital. A further focus of the Group is the prevention of further falls. Falls may be an issue for patients on discharge and there is a need to ensure they are referred appropriately and followed up. The Strategic Community Falls Prevention Group are also linking in with national work via the national taskforce.

The National Clinical Lead for Falls and Frailty is setting up an All Wales Inpatient Falls Network. The main role of the group will be to plan work as one team to address the recommendation of National Audit of Inpatient Falls (NAIF) and also develop the All Wales Inpatient Falls pathways. Representation from the Health Board has been identified and agreed with representatives from Medical (acute), Nursing (acute), Therapies and Pharmacy.

The National Audit of Inpatient Falls is currently being undertaken and completed. The Health Board has been granted an extension until 6th April 2021.

The Prevention and Management of Adult In-patient Falls Policy has been reviewed as part of the three year review and a mapping exercise has been undertaken to ensure standards set out by NICE are being adhered to.

The All Wales Falls and Bone Health Assessment tool has been launched and replaces the pathway.

A BCU Standard Root Cause Analysis (RCA) Tool has been established incorporating current practice from across the Health Board. Feedback from the pilot areas has been positive. Further work is underway to ensure the investigation process is comprehensive with associated documentation easy to locate and appropriately referenced as well as not being overly complicated, repetitive or onerous.

### **WELSH GOVERNMENT REPORTABLE SERIOUS INCIDENTS**

A serious incident is defined as an incident (not exclusively a patient safety incident) that occurred in relation to NHS funded services and care resulting in:

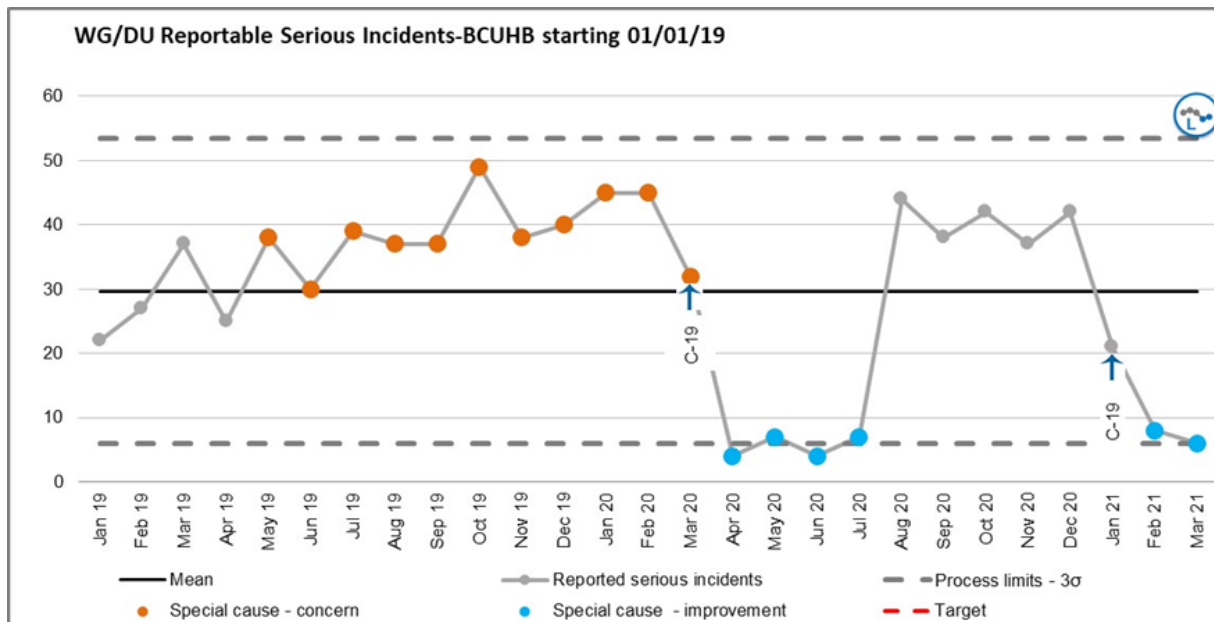
- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- permanent harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy (this includes incidents graded under the National Patient Safety Agency (NPSA) definition of severe harm);
- a scenario that prevents or threatens to prevent an organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment;
- a person suffering from abuse;
- adverse media coverage or public concern for the organisation or the wider NHS;
- the core set of 'Never Events' as updated on an annual basis.

Welsh Government provide a list of serious incidents that require formal notification if reported. This list is not exhaustive and notification of any incident resulting in serious harm must always be considered as Welsh Government reportable.

In October 2020, the NHS Wales Delivery Unit took on the responsibility for oversight of serious incidents on behalf of Welsh Government in anticipation of the NHS Wales Executive being formed. The Corporate Patient Safety and Experience Department has met with the NHS Wales Delivery Unit and will continue its strong working relationship with them.

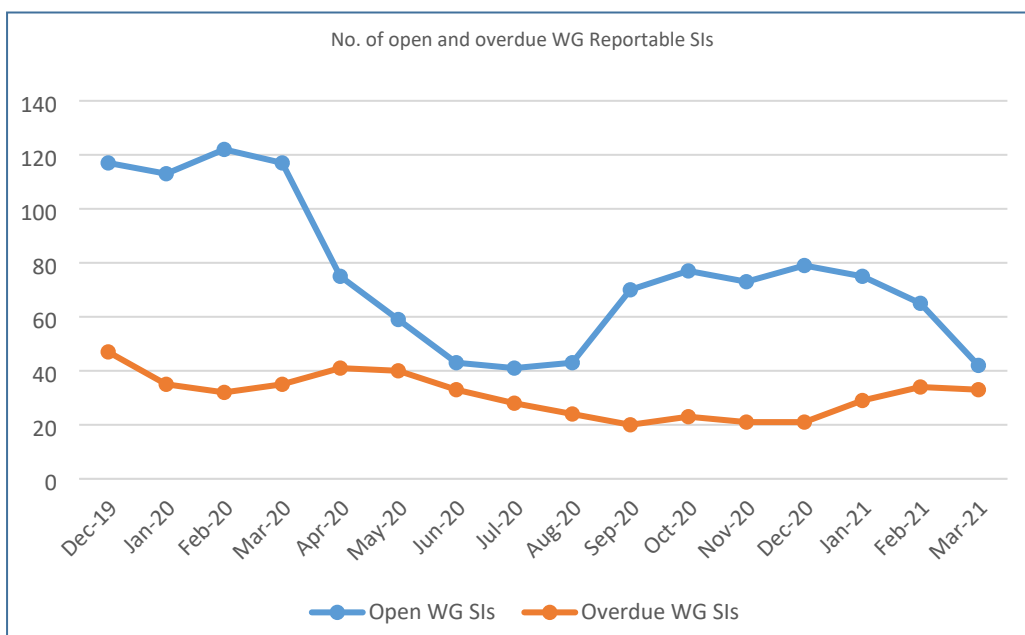
During the initial Covid-19 outbreak, Welsh Government reduced their list of reportable serious incidents, including healthcare acquired pressure ulcers (avoidable) and falls with harm, consequently resulting in a sharp decrease in the number reported during Quarter 1 (see graph below). Reporting returned to the previous (pre-Covid-19) process as of August 2020 and a clear increase in reporting was seen in Quarter 2, (see graph below). As of 4<sup>th</sup> January 2021, in response to increased pressure to services as the number of patients admitted with and staff testing positive for Covid-19, the Welsh Government reintroduced their reduced list of reportable serious incidents, thus the fall in numbers of incidents reported to Delivery Unit (DU).

The new incident and serious incident process is being rolled out during Q1.



Only six incidents were reported to the DU during Q4, three of which were the death of children which are being investigated under PRUDiC procedures (these are not necessarily deaths that have happened within the Health Board, it could be a child who has been involved in a road traffic collision and has been brought into the Emergency Department).

At the end of Quarter 4, 44 serious incidents remain open with Welsh Government (down from 82 in Q3) of which 36 are overdue (up from 23 in Q3). Of these, the predominance of overdue incidents relate to Central Acute (13), West Acute (7), East Acute (5), Corporate Safeguarding (all PRUDiC) (5) and East Area (3). All divisions have seen a reduction in open reportable incidents due to the change in reporting guidelines from Welsh Government. A small number of incidents are overdue by twelve months (2) and these relate to matters subject to police investigation. A number (2) are overdue by 6-12 months.



Overall completion of reportable serious incident investigations within the 60 day national target has decreased to 56% from 65% in Q3. It should be noted that there have been ongoing delays with the allocation of Investigating Officers (IO) and Chair's for Serious Incident Reviews. The role of IO is mainly assigned to a member of the governance team and many have been redeployed back to clinical duties during the latest wave of the COVID-19 pandemic. Organising Serious Incident Reviews has also been challenging with clinical staff having conflicting clinical priorities leading to meetings having to be rearranged three or four times.

#### **WELSH GOVERNMENT SENSITIVE ISSUES**

Sensitive issues (or no surprise) notifications are reports to the Welsh Government which provide them with brief details of incidents that may be politically sensitive, high media profile or have the potential to impact upon the reputation of the Health Board. There were 13 sensitive issues reported to the Welsh Government in Q4 because of possibility of media interest; all of which have been reported via Datix as an incident and are being investigated through usual procedures.

#### **PRESSURE ULCERS**

Currently the figures for the number of avoidable pressure ulcers (grade 3, grade 4 and unstageable pressure ulcers) is not available since the criteria for reporting was changed in response to the COVID-19 pandemic. Avoidable pressure ulcers were reported to the Delivery Unit only following investigation that had confirmed the pressure ulcer was avoidable, a closure form and a notification form would be submitted to the DU simultaneously. There is currently no robust system in place whereby services report corporately to confirm if a Grade 3, 4 or unstageable pressure ulcer is avoidable following local review at harms meetings.

In Q4, 567 Grade 3, 4 and unstageable pressure ulcers were reported on Datix. Of which 343 related to patients admitted with the pressure ulcer.

The Patient Safety Team have recently begun monitoring the completion of All Wales Review Tool (AWRT) which determines whether a pressure ulcer, on initial review, is avoidable (therefore health acquired) or unavoidable. Of a sample of 90 AWRT that were reviewed within 72 hours of reporting a pressure ulcer, only three have been deemed avoidable. In addition, the Patient Safety Lead has commenced a piece of work scoping the reporting and incident management of pressure ulcers. This work is being supported by a member of the governance team from Ysbyty Gwynedd as part of the new incident process and procedure.

#### **PATIENT SAFETY STRATEGIC PLAN**

In Q3 it was reported that the Health Board had reviewed its need for a Patient Safety Strategy and had requested a Patient Safety Strategic Plan which will form a suite of strategic plans (with Patient Experience; and Clinical Effectiveness) that will sit underneath the overarching Quality Strategy. The Strategic Plan is now in draft format and is currently being reviewed. The work was deferred due to the second wave of COVID-19.

## NEVER EVENTS

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. The Welsh Government issues a list of serious incidents that are deemed to be Never Events. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event. Never Events require full investigation under the Serious Incident Framework.

During Quarter 4, there were no Never Events reported.

The investigation into the most recent Never Event “Overdose of Methotrexate for non-cancer patient” went to serious incident review meeting and the final report remains outstanding. Early learning from the MIS plus indicate that this patient was a new initiation of Methotrexate, on discharge from the acute hospital. This is a very rare event in its own right and the Methotrexate policy is predominantly focussed on outpatient prescribing, supply and administration. Whilst the patient was counselled on the correct administration and dosage of Methotrexate on discharge, this was not documented in the notes. As the patient was on the ward, a methotrexate booklet (drug information and monitoring record) was not supplied with the discharge prescription. It should be clear on the discharge that this was a new medicine and therefore a book needed to be supplied (normally part of counselling in an out-patient setting). An 8 week supply was made (to fit in with shared care arrangements) but the policy states a maximum of 4 weeks for take home drugs (one dose for inpatients).

In total, five Never Events were reported in 2020 – three fall into the “wrong site surgery” bracket and the lack of or failure to use a LocSSIPs (Local Safety Standards for Invasive Procedures) is a theme. Progress has been made in the design of a virtual library for LocSSIPs and NatSSIPs (National Safety Standards for Invasive Procedures) with the use of 365 SharePoint to store the LocSSIPs and NatSSIPs. This is now accessible though the intranet and the library has been populated with a number of LocSSIPs. It is currently being piloted with a view to official launch in the near future.

The independent review of a never event in urology services was received and an assessment made of the findings against the internal investigation action plan. One area has been identified for further work which is the development of human factors capability. This is being taken forward by the Corporate Patient Safety Team and a multi-disciplinary working group, under executive leadership of the Executive Medical Director.

## INQUESTS

“An inquest is an inquiry into the circumstances surrounding a death. The purpose of the inquest is to find out who the deceased person was and how, when and where they died and to provide the details needed for their death to be registered. It is not a trial.” (Gov.UK)

HM Coroner notifies the Health Board when they have opened an inquest into the death of a BCUHB service user and they require further information from the Health Board. These cases are logged on the BCUHB Claims Datix system and managed by the Inquest Team.

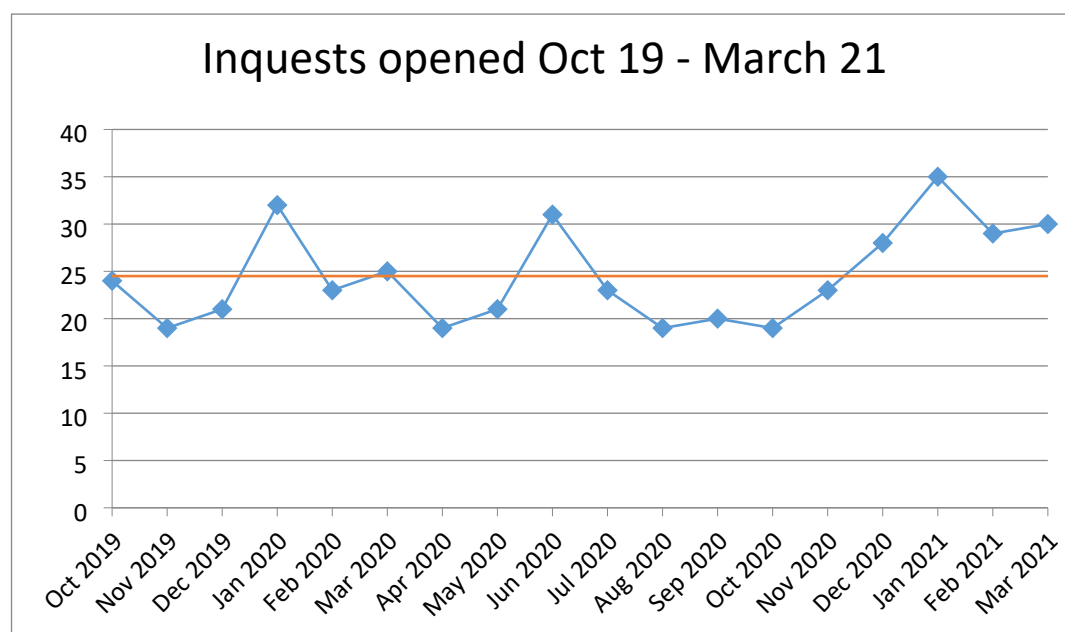
### Inquests Opened

The Health Board has received notification that the Coroner has opened 94 new inquests during Q4 requesting information from the Health Board.

The following chart shows the inquests opened by region and overarching service

	BCUHB Central	BCUHB East	BCUHB West
Anaesthetics, Critical Care and Pain Management (Secondary)	0	2	3
Cancer Services (Secondary)	0	1	1
Division of Mental Health and Learning Disabilities	11	6	4
Surgery (Secondary)	7	3	1
Women's and Maternal Care (Secondary)	0	0	1
Specialist Medicine (secondary)	20	20	9
No service assigned	1	2	2

The chart below shows the variation in numbers of inquests opened from October 2019, up to the end of March 2021, demonstrating the variation from month to month.



## Inquest Listings / Hearings

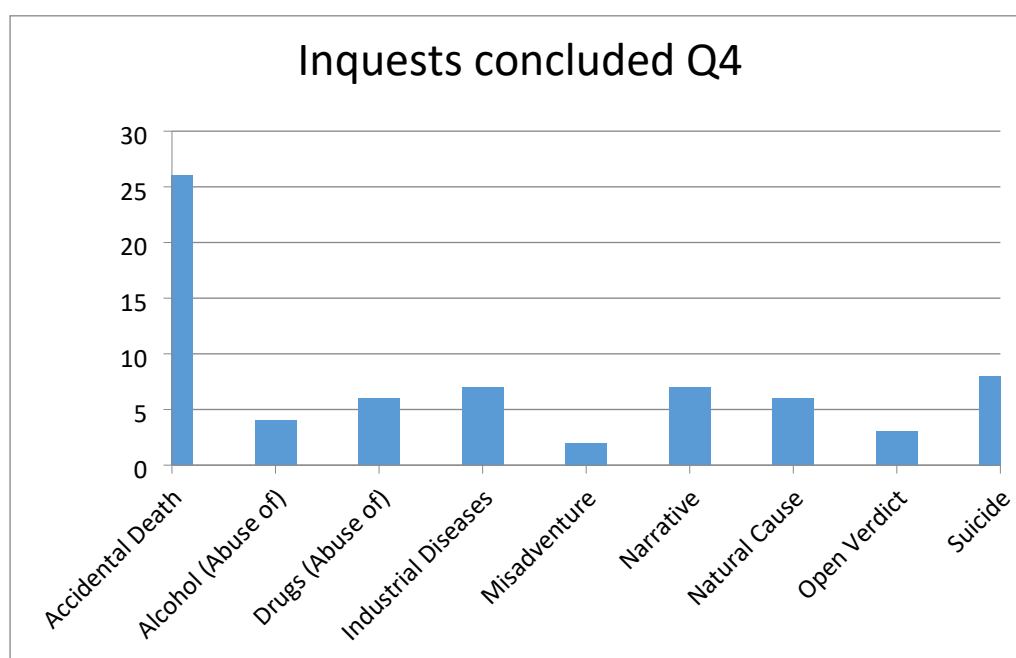
In total, 69 inquests were concluded during Q4. Although inquest hearings recommenced in September 2020, the majority of these inquests were heard under Rule 23 (read only inquests, witnesses not required). HM Coroner had planned to recommence listing inquests with witnesses called in the New Year (Q4) however due to ongoing demands with COVID-19 these were again postponed.

A number of Rule 23 inquests continued to be heard, but only a small number of inquests with BCUHB witnesses were listed. The witnesses who were called gave their evidence via video link with the Court, using HM Coroner secure system.

Availability is now being requested from BCUHB staff for inquests with witnesses from April 2021 onwards, with a view to staff members giving their evidence via secure video link from within BCUHB premises.

## Inquest conclusions and Prevention of Future Deaths

The chart below shows the inquest conclusions for those listed and closed during Q4.



At the conclusion of each inquest, HM Coroner has a duty to consider whether to issue a Regulation 28 report, or Prevention of Future Deaths (PFD) report. As part of the inquest process, where there is learning associated with an inquest, the Inquest Team ensures that the most up-to-date version of the relevant action plan is shared with HM Coroner in order to provide evidence that the Health Board is already taking appropriate remedial measures.

During Q4, no PFDs were issued by HM Coroner to the Health Board.

## **Inquest learning**

Although inquest conclusions were previously shared post inquest, staff members who were not required to give evidence were not always aware when an inquest would be taking place, and on occasion only found out from seeing reports in the press. During Q4 process has been introduced to alert staff members who have provided statements/evidence for inquest, that the inquest date has been set. Once the inquest conclusion is received from HM Coroner's office, this information is also shared with the staff members.

At an inquest in March 2021, although no PFD was issued, the Coroner felt that the ward in question could have better supported the patient and their family with better use of communication methods. The patient's admission and death had been during the COVID-19 pandemic, which meant that in person visiting was seldom possible. The Coroner suggested a greater use of I-pad and telephone communication to assist with family support.

## **Inquest Training**

During Q4 Inquest Awareness Training continued to be provided, by way of face-to-face training sessions, held in a socially distanced environment, as well as the introduction of training via Teams. Feedback from the training sessions is excellent, with staff commenting positively regarding the level of support available, and the informative nature of the sessions.

It has been identified that some areas within the Health Board require focussed training with regard to statement writing in order to ensure that the statements provided meet the required standard. In order to help achieve this, bespoke training sessions are being arranged directly with the teams involved.

## **Inquest Board Round**

The Inquest Board Round continues to be held virtually via Teams. The meeting purpose is to track progress and escalate any issues or delays in order to support an efficient process and enable effective communication of responses/timescales to the Coroner.

During Q4, the Inquest Board Round for the East and West localities were affected by the lack of senior staff availability due to the impact of Covid-19, however communication channels were maintained in order to progress inquest cases.

Since the number of COVID-19 cases has reduced, the number of senior clinical staff able to participate in the meetings is increasing. It is noted that delays are reduced when senior staff members are able to be present at the Inquest Board Round, as they are effective in 'unblocking' and identifying appropriate courses of action.



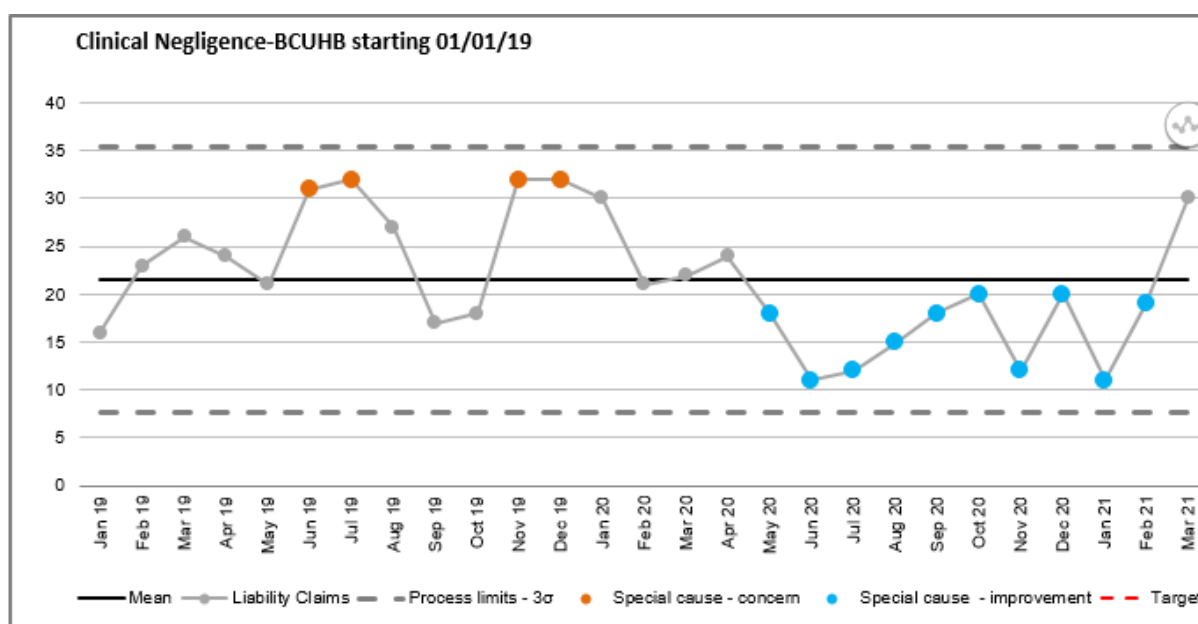
## Future Development of Inquest Processes

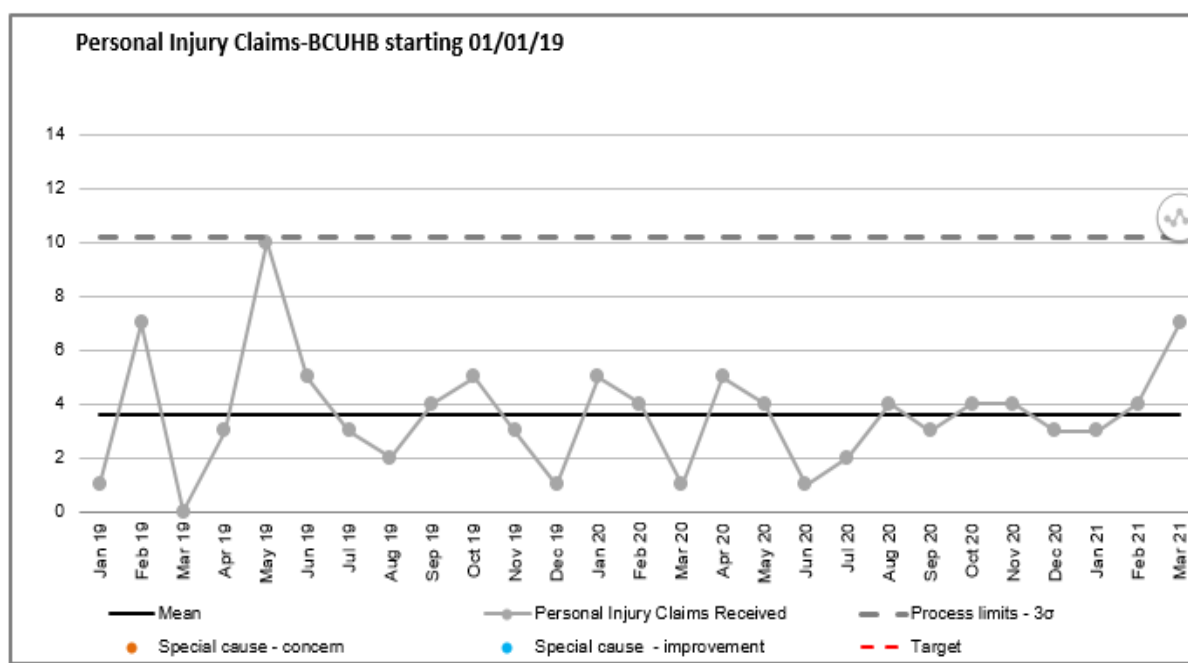
The Inquest team continues to be involved in the All Wales inquest process review, and have shared the BCUHB Inquest Standard Operating Procedure (SOP) and associated tools with the Inquest Network in order to help facilitate development of a generic procedure. This has been delayed by the ongoing impact of Covid-19. In order to ensure appropriate inquest management within BCUHB, our inquest SOP is undergoing review/update in advance of any all-Wales generic procedure.

### LITIGATION

During Quarter 4, 74 claims or potential claims were received against the Health Board. Of these, 60 related to clinical negligence and 14 related to personal injury.

The Health Board are now seeing an increase in claims during Q4. When looking back at Q1 and comparing, Q1 was the start of the Covid-19 pandemic and it was anticipated that the Health Board would see a further rise in claims as business began to return to a new normal. Q3 was the start of a further lockdown and claims were fluctuant. This increase in Q4 is therefore as expected.





## Significant claims and learning

During Q4, 90 claims were closed. Of these, 72 related to clinical negligence and 18 related to personal injury. The total costs for these closed claims amounted to £6,415,732.42 before reimbursement from the Welsh Risk Pool. The most significant claims and related learning are detailed below:

- i. Failure related to an unnecessarily performed Endoscopic retrograde cholangiopancreatography (ERCP), which resulted in severe post ERCP pancreatitis, pancreatic necrosis, and sepsis. (£80,544.30)

### Learning:

The endoscopy department no longer relies upon locum doctors for provision of an ERCP service; its substantive doctors who provide the service are fully trained in the diagnostic workup of these patients.

The endoscopy department has learnt the importance of selecting candidates for ERCP according to local and national guidelines.

An audit on ERCP indications has been completed and the issues and learning from this case was shared with the Endoscopy Users Group.

- ii. Allegations relate to a delay in the diagnosis of a bowel perforation. There was a failure to carry out further investigation such as a CT/ultrasound scan to confirm a diagnosis. Had the correct diagnosis been made when the Claimant initially attended, he would have avoided the significant abdominal symptoms that he now suffers from. It was also alleged that patients with communication difficulties should be kept in overnight to ensure symptoms are resolving. (£390,556.82)

#### Learning:

The practice of the surgical department has changed in the years since this incident, and it is now standard practice for patients in this situation to have a diagnostic CT. One of the drivers for this change has been the introduction of the National Emergency Laparotomy Audit (NELA); a diagnostic CT has been set as one of the standards for this audit. The availability of CT scans has improved considerably since this incident, because the hospital now has an extra CT scanner.

As an alternative to overnight admission, facilities have recently been improved for ambulatory care by opening the SDEC (same day ambulatory care) unit.

- iii. Delayed diagnosis of fracture of child which resulted in right radial nerve palsy identified on the second visit to the Emergency Department (ED). Mother believes this was preventable if the fracture had been spotted and treated appropriately on the daughter's initial visit to ED.

#### Learning:

Issues identified with interpretation of x-ray. All doctors and nurse practitioners have regular teaching sessions on x-ray interpretation for limb injuries and there is a set timetable within the department for the Royal College of Emergency Medicine (RCEM) curriculum. In addition, the ED senior team review radiology reports in a timely fashion to cross-check any discharged patients without any follow up as a safety net.

- iv. Failure to carry out timely caesarean section as a result of which baby sustained foetal distress and hypoxic ischaemic encephalopathy in the neonatal period.

#### Learning:

There are regular audit sessions held by Clinical Supervisors of Midwives during which midwives review notes including cardiotography (CTGs). Concerns or trends noted from these reviews are also flagged to the Head of Midwifery. Monthly audits occur of time taken from decision to performance of Cat 1 c-sections and recorded against Labour Ward statistics.

- v. Immunisations given to baby that were not appropriate and issues with leaving baby on a ventilator for too long caused delayed stay in Special Care Baby Unit (SCBU).

#### Learning:

Issues identified were importance of paying attention to basic physiological measurements as signs of illness or failure to respond to treatment. Further extreme caution should be taken in the use of hypotonic IV solutions especially as maintenance fluids. A much more detailed Intensive Care Unit

(ICU) care proforma paperwork is used for seriously unwell babies. Blood pressures reading issues would be obvious on this paperwork. A standardised ward round sheet has also been implemented since this incident for all babies therefore unsuitable fluid regimes are likely to be spotted early and courses of treatment changed.

- vi. A nurse was hit in the head by a hoist. She sustained vestibular system damage, as well as a soft tissue injury to the back; she also suffered with panic attacks and anxiety

#### Learning

The hoist has now been withdrawn from use. Training on the new hoist has been up-graded to include the spread-bar and include the importance of keeping it under control at all times and replacing back in the cradle when not in use to prevent any possible injury. A clinical alert was updated and reissued and training materials have been up-graded.

- vii. Delay in diagnosing appendicitis which resulted in an emergency appendectomy being required. There was bowel perforation during that procedure which, due to the patient's failure to improve, required transfer to Manchester Children's Hospital.

#### Learning:

Settlement was advised by Counsel in this case without making admissions as there were clear vulnerabilities if this case was taken to trial. Although no admissions were made that the stitch was impaled into the bowel during the appendectomy procedure, this case was shared in the Governance meeting to ensure awareness across BCUHB.

With regards to clinical negligence, the Health Board has noticed a significant trend in claims for negligence surrounding the use of TransVaginal Tension Free Tape (TVT) Mesh in gynaecology cases over Quarter 4. This follows a larger group claim, which has been brought against the manufactures of the TVT Mesh Devices. Generally, the allegations revolve around:

- whether consent was properly obtained prior to implanting the Device;
- and whether the care, management and treatment received by the claimants in respect of their condition was of the appropriate standard.

As expected the largest number of open claims continue to relate to Surgery, Specialist Medicine and Women and Maternal Care. This is not an unusual profile of specialities within the NHS.

### **Themes identified from personal injury claims**

The following themes have been identified during Q4 for personal injury:

A rise in the numbers of claims relating to the following:

## 1. Slips/trips

Other categories remain steady and we continue to see claims being brought for the breaches of Data Protection.

Personal Injury claims savings due to discontinued or favourable settlements for this period were £52,285.01

All settled claims require completion of a Learning from Events Report. This records the findings of investigation and any actions taken and is jointly developed by the claims manager and relevant clinical lead. This report must be submitted to the Welsh Risk Pool in order to reclaim costs.

The Welsh Risk Pool (WRP) arrangements require that individual NHS bodies meet the first £25,000 of any claim or loss. Thereafter the NHS bodies can submit a reimbursement request to the WRP for consideration and approval. The WRP administers the risk pooling arrangements and meets the cost of financial losses over £25,000. All Health Boards and Trusts across Wales have been advised by the Welsh Risk Pool that the annual revenue allocation from the Welsh Government is not sufficient to meet the value of forecast in year expenditure. Welsh Government have now confirmed that additional contributions will be required. BCUHB's share of the increase will be 17.07% and an additional cost of £2.35m in addition to the contribution already made, creating a significant impact on the overall financial position.

The Claims Team have experienced some issues with the return of documentation and/or evidence from the Workforce, Organisation and Development Department and some nursing areas. Through escalation processes however these have been rectified.

## **Redress**

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 state if at any time during the investigation of a complaint or patient safety incident it is considered that a qualifying liability that would attract financial compensation of £25,000 or less exists or may exist, it must be determined whether or not an offer of redress should be made.

Redress can include one or more of the following:

- A full explanation of what happened;
- An apology;
- An offer to provide care or treatment (where appropriate); and
- A report on action which has been, or will be taken to prevent similar cases arising; and/or
- Financial compensation.

During Q4 2020-21, 13 cases were concluded which involved Redress:

- 4 offers of financial compensation as redress were accepted totalling £25,042.75

- 1 written apology was made
- 5 proceeded to become a clinical negligence claim
- 3 were advised to pursue a clinical negligence claim as any offer of financial compensation made would exceed the £25,000 limit allowed under Putting Things Right.
- 16 other responses were sent during the period which had been reviewed for redress but deemed to have no qualifying liability.

Redress offers accepted during this quarter were about the following issues:

Missed fracture (cuboid)

**Learning:** Reminder has been sent to all ED staff who request x-rays of the importance of indicating “point of maximum tenderness”

Missed fracture on CT angiogram (vertebrae)

**Learning:** Reporting discrepancy highlighted and images reviewed by Consultant Radiologists in a Discrepancy Review meeting for wider learning.

Delay in Ear Nose and Throat (ENT) diagnosis and treatment

**Learning:** Clinicians reminded to consider cholesteatoma, particularly when undertaking an examination of an ear under anaesthesia.

Preventable pressure ulcer

**Learning:** Tissue viability training for all staff on Older Persons Mental Health ward. Staff to have the opportunity to shadow tissue viability nurses to improve their awareness.

Preventable pulmonary embolism

**Learning:** A Thromboprophylaxis pathway chart now recommends including Fondaparinux as an alternative medication in the case of allergy to Clexane.

To ensure that learning and improvements are actioned at the earliest possible stage, the Welsh Risk Pool requires the Health Board to submit a Learning from Events Report (LFER) within 60 working days of a qualifying liability being determined within a complaint or incident investigation – this process includes the actions that the Health Board have put in place. The LFER will be considered by the WRP Committee who will approve reimbursement to the Health Board for the costs entailed in each redress case, once satisfied with the evidence of learning provided.

During Q4 2020-21 the Welsh Risk Pool approved the learning in 33 redress cases.

## PATIENT SAFETY ALERTS

### Circulated Jan – March 2021

All alerts by Type and Action Type	Immediate Action	Action	Product Recall	For Information	Total
<b>Manufacturer Safety Notice</b>	1	2	0	0	3
<b>Medical Device Alert</b>	0	1	0	0	1
<b>Field Safety Notice</b>	2	5	2	3	12
<b>Total</b>	3	8	2	3	16

Internal Alert	Ref	Alert Title	Date issued
	INT001MD	Arjo - Lifeguard 20, Lifeguard 50, Lifeguard 55 Patient Trolleys.	26-Jan-21
	INT002MD	BD 16G Cannula Alert	26-Jan-21
	INT003MD	T34 Syringe Driver Batteries 2nd 3rd Edition	Feb-21
	INT004MD	Iloprost - Risk of Incorrect Dose	25-Mar-21

### Current Active Alerts

Reference	Type	Title	Date issued	Brief - Description	Current Stage	Deadline action to be
PSN034/September 2016	PSN	Supporting the introduction of the National Safety Standards for Invasive Procedures	28/09/2016	Never Events related to invasive procedures comprise over 65% of all reported Never Events in NHS Wales. The total number of Never Events reported between 16 October 2014 and 15 October 2015 was 24; 16 of these related to invasive procedures:	SharePoint has now been created - <a href="https://nhs.wales365.sharepoint.com/sites/BCU_SIPPS?e=1%3A6e395a17501b4e9fa598fc6a449e9409">https://nhs.wales365.sharepoint.com/sites/BCU_SIPPS?e=1%3A6e395a17501b4e9fa598fc6a449e9409</a> There are still outstanding LocSSIP's to be uploaded and the PST are currently working through these for upload. Launch date will be before July 2021.	28/09/2017
PSN055/October 2020	PSN	The Safe Storage of Medicines: Cupboards notice replaces the PSN 030 issued April 2016	22/10/2020	Designed and appropriate storage of medicines can reduce waste and medication errors arising from selection of the incorrect medication and omission of doses.	The Safe Storage of Medicines: Cupboards notice replaces the PSN 030 issued April 2016	30/09/2021
PSN056/October 2020	PSN	Foreign body aspiration during intubation, advanced airway management or ventilation	26/10/2020	Loose items unintentionally introduced into the airway during intubation, ventilation or advanced airway management (known as foreign body aspiration [FBA]) can lead to partial or complete airway blockage or obstruction. If the cause is not suspected, this can be fatal.1 Complications following FBA may not be immediately recognised due to sedation and anaesthesia and may be postoperatively misdiagnosed as asthma, chronic obstructive pulmonary disease (COPD), or stridor	Action 1b: Trust wide response completed  We have been in touch with the suppliers have confirmed that the backings of the Electrodes will be changed in line with the PSN by the 01st of July 2021.  During this transition period  The long descriptions have been added to all products	01/07/2021

The Internal Audit into the Safety Alert process has been received and is being reviewed. Further detail will be included in the next report.

## **ONCE FOR WALES CONCERNS MANAGEMENT SYSTEM (OFWCMS)**

There is still no national project plan or key milestones with dates from the RLDatix Team and WRP which is impacting on the ability of the organisation to develop an implementation plan for BCUHB. The risk is shared by Health Boards across Wales and has been raised in the HoPE Network.

Despite this, the complaints modules, claims and redress modules as well as the incidents module was expected to go “live” on 1<sup>st</sup> April 2021. Based on the lack of a system to train staff and the fact that up until the middle of March no system had been built and tested the Health Board took the decision to delay the launch until 1<sup>st</sup> July 2021. Only four Health Boards across Wales opted to go live on 1<sup>st</sup> April 2021 and unfortunately RL Datix and WRP had to reduce this to one, Hywel Dda University Health Board, as there were 32 issues/defects identified during the launch weekend that required resolution before the system could be rolled out to the other health boards. Hywel Dda University Health Board will now test the system.

The Health Board has updated its readiness plan for the introduction of the new system, based on the assumption that the Health Board will receive the new system on 1<sup>st</sup> June 2021 to enable training to take place.

The Health Board Concerns and Quality Management System Group continues to monitor the implementation across Wales very closely and will update the readiness plan and the risk profile accordingly.

## **10. CONCLUSIONS AND RECOMMENDATIONS**

This report provides the Quality, Safety and Experience Committee with information and analysis on significant patient safety issues arising during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway. The aim is to provide the committee with assurance on the Health Board’s work to improve patient safety.

The QSE Committee is asked to note the report.

The QSE Committee is asked to note the focus on improving learning, reducing incidents resulting in avoidable harm and the evolving improvement of assurance in this area recognising significant work remains.

The QSE Committee is asked to note the delay of the Once for Wales Concerns Management System.

The QSE Committee is asked to receive this report and provide feedback on its evolving content and layout.



<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	Quality, Safety and Experience (QSE) Committee 4 <sup>th</sup> May 2021						
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public						
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	Quality and Performance Report						
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Mr Mark Wilkinson, Executive Director of Planning and Performance						
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Mrs Kamala Williams, Interim Director of Performance Mr Ed Williams, Head of Performance Assurance						
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	The data and information in this report has been scrutinised by the Executive Director of Planning & Performance						
<b>Atodiadau</b> <b>Appendices:</b>	1. Quality and Performance Report to 31 <sup>st</sup> March 2021						
<b>Argymhelliad / Recommendation:</b>							
The Committee is asked to note the report							
Please tick as appropriate							
<b>Ar gyfer</b> <b>penderfyniad</b> <b>/cymeradwyaeth</b> <b>For Decision/</b> <b>Approval</b>		<b>Ar gyfer</b> <b>Trafodaeth</b> <b>For</b> <b>Discussion</b>		<b>Ar gyfer</b> <b>sicrwydd</b> <b>For</b> <b>Assurance</b>		<b>Er</b> <b>gwybodaeth</b> <b>For</b> <b>Information</b>	
<b>Y/N to indicate whether the Equality/SED duty is applicable</b>							<b>N</b>
<b>Sefyllfa / Situation:</b>							
<p>It should be noted that due to the continued COVID-19 pandemic Welsh Government will not be performance managing Health Boards based on the performance measures included in this report, however, monitoring and publishing of the data has recommenced.</p> <p>This report includes available indicators (measures) from the National Delivery Framework, together with a section on COVID-19.</p> <p>The Committee are asked to note the following:</p> <p>Since testing commenced last year 773,408 tests have been carried out (as at 19<sup>th</sup> April 2021) of which 37,874 were positive for COVID-19. The average turnaround from Test to Result is currently 100% within 24 Hours, with an average Test to Result taking 3 hours.</p> <p>The COVID-19 vaccination programme continues at pace with BCUHB being the first Health Board in Wales to vaccinate at least 20% of its population. As at 19<sup>th</sup> April 525,539 vaccinations have been delivered across the Health Board, which represents an increase of 323,207 vaccinations compared to the position last reported to QSE, which was at 20<sup>th</sup> February 2020.</p>							

Despite the adverse impact of the COVID-19 pandemic on the majority of planned care services, it is encouraging to note that our immunisation of children programme has continued to meet the national delivery measure, at 95.5% of eligible children receiving 6 in 1 Hexavalent (national delivery measure =>95%). With regards to eligible children receiving 2 doses of MMR vaccinations by age 5 we have achieved 93.5% against the national delivery measure =>95%.

Our seasonal flu campaign began in late September and by the end of March we have exceeded the 75% target for over 65's at 78.15%. The 60% target rate for staff was surpassed in November and we achieved a rate of 70.35% at the end of March.

Infection control benchmarking against other Health Board is included in this report, see page 11. For the rolling period April 2020 to March 2021 BCUHB was the best performing Health Board on two measures (MSSA bacteraemia and Klebsiella bacteraemia rates per 100,00 population) and was ranked second best in terms of MRSA bacteraemia rates per 100,00 population. BCUHB did not rank 6<sup>th</sup> (worst performing) on any of the other 3 measures.

Adult Mental Health services continue to recover as services are re-established. Over the course of the pandemic there has been a deterioration in the rate of children being assessed or starting therapy within 28 days of assessment. The relevant national delivery measure is =>80% with our actual performance being 22.41% in February 2021. Although this represents a significant adverse variance from the measure we are on an upward trajectory with performance against the measure at 17.4% in December 2020. Details of the actions being taken to sustain improvement and achieve the measure are included on page 15 of the report. For Adult Mental Health there has been a slight deterioration in performance compared to December 2020, however the number of patients starting therapy within 28 days of assessment remains above the =>80% target at 87.38% in February 2021.

The number of patients experiencing delayed transfer of care (DToC) within our mental health service has improved from 16 patients delayed in January compared to 12 patients in March 2021. The number of bed days associated with mental health DToC has also decreased over the same period from 2,913 in January to 819 in March 2021. The service has developed and commenced implementation of an improvement plan, see page 17, and it is expected that the number and length of DToCs will continue to fall over the coming months.

Performance against the 26 Week target for children awaiting neurodevelopment assessment remains poor at 25.98% against the measure of =>80%. The March 2021 position is a slight improvement on the 23.82% previously reported to QSE. Plans recently approved, see page 16, will significantly increase capacity to undertake assessments, however, it should be noted that referrals are still significantly below pre pandemic levels and are anticipated to increase.

With regards to serious incidents (reportable to Welsh Government) there were no 'Never' events in the period. A new process for incident and serious incident management will be rolled out from April 2021, see page 20 for further details.

The 12 month rolling crude mortality rate for ages 75 years and under remains below the All Wales average BCUHB rate 1.13% compared to 1.44% All Wales at February 2021. Rates have increased during the last quarter in line with the second COVID-19 surge although in keeping with the crude mortality rate the 0.11% increase for BCUHB is slightly lower compared to All Wales increase of 0.19%.

The % of hip fracture patients receiving orthogeriatrician reviews within 72 hours of a hip fracture is improving, however, the variation across North Wales continues. Performance for March 2021 was as follows –Ysbyty Glan Clwyd 100%; Ysbyty Gwynedd 72.4%; Wrexham Maelor 68.7%; the national delivery measure =>75%

Concern remains regarding the recording and monitoring of the provision of Sepsis Six bundles for Inpatients and Emergency Departments the actions being taken to address the barriers to compliance are detailed on page 42.

### **Cefndir / Background:**

Our report outlines the key performance and quality issues that are of priority for the Health Board. The summary of the report is now included within the Executive Summary pages of the Q&P and demonstrates the work related to COVID-19 as well as the key measures contained within the 2020-21 National Delivery Framework. This framework has been revised to provide performance measures under the Quadruple Aims set out in A Healthier Wales.

### **Asesiad / Assessment & Analysis**

#### **Strategy Implications**

The performance measures within the report are aligned with the National Delivery Framework.

#### **Options considered**

Not Applicable

#### **Financial Implications**

The delivery of the performance indicators contained within our annual plan will have direct and indirect impact on the financial recovery plan of the Board.

#### **Risk Analysis**

The present pandemic has produced a number of risks to the delivery of care across the healthcare system. The paper highlights the risks arising directly from Covid-19 and the need to maintain essential non-Covid-19 services. The impact of Covid-19 on non-Covid-19 planned care is reported together with the interdependencies between ensuring safe re-start of elective care and balancing the risk of covid-19 for patients, staff and system capacity.

#### **Legal and Compliance**

This report will be available to the public once published for the Quality, Safety and Experience Committee

#### **Impact Assessment**

The Report has not been Equality Impact Assessed



# Quality and Performance Report



## Quality, Safety & Experience Committee

## March 2021

## COVID-19 Pandemic

It should be noted that all services continue to be impacted upon by the COVID-19 Pandemic, and/or the measures put in place to combat the spread of COVID-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported herein is not compared as 'like-for-like' to previous year's performance or to current and previous targets.

### Report Structure

The format of the report reflects the published National Delivery Framework for 2020-21. This aligns to the Quadruple Aims contained within the statutory framework of 'A Healthier Wales'.

Additional sections are added to reflect Covid-19 key performance indicators and the work on maintaining essential services.

The report is structured, so that measures complementary to one another are grouped together. Narratives on the 'group' of measures are provided as opposed to looking at measures in isolation.

This report contains data showing the impact of the pandemic on referrals, planned care activity and waiting lists.

### Performance Monitoring

Performance is measured via the trend over the previous 6 months. The Trend is represented by RAG arrows as shown below.



Performance has improved over the last 6 months



Performance has got worse over the last 6 months



Performance remains the same

### Operational Plan Monitoring

The operational planning for 2020-21 has been impacted by the pandemic with planning cycles re-defined essentially into quarterly plans.

The Quarter 3 and 4 operational plan has been approved by the Board and submitted to Welsh Government. The likelihood of delivery of the actions contained within this plan are reported in the accompanying Q3 and Q4 Operational Plan Monitoring Report.

As a consequence of the changes in the planning cycle for 2020-21 and the uncertainty around the future levels of COVID-19 the ability to produce month on month profiles to monitor performance against is severely limited.

### Ongoing development of the Report

The intention for future reports is to continue to align the reporting of COVID-19 related pandemic indicators with the essential services service status and the National Delivery Framework while developing the reporting against the actions in the operational plans.

As patient and staff safety permit, we will recommence the development of profiles for delivery for activity taking place in short-term cycles, reporting on referrals, new ways of working, emergency and elective activity and waiting lists.





## Key Messages

National Lockdown continues due to high number of cases and a new variant of COVID-19

COVID-19 admission rates continuing to fall

Essential services largely maintained, however activity remains significantly reduced

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The Committee are asked to note the following:

## COVID-19 Update

The vaccination programme continues at pace with a total of 525,439 vaccinations given across the region as at 19<sup>th</sup> April 2021. This is an increase of 155,258 since the week commencing 22nd March 2021. Of the total vaccinations given 155,059 were second dose vaccinations.

A total of 773,408 tests have been undertaken since January 2020, 37,874 of which were positive for COVID-19. The turnaround from Test to Result within 24 hours is now reported as 100%, with an average test to result time of 3 hours.

## Quadruple Aim 1: Prevention

Our end of year position for seasonal flu vaccinations for Health Care workers saw an uptake rate of 70.35%, exceeding the 60% target and the highest ever position for BCU staff.

The latest available position for childhood immunisations is the Qtr 3 position showing a small upward trend in the delivery of 2 doses of the MMR Vaccine by the age of 5, the position has risen from 93.4% to 93.5%. The 6 in 1 childhood vaccine has shown a drop over the quarter from 96.5% to 95.5%.

The childhood immunisation programmes have continued as essential services during the coronavirus pandemic, with appropriate assurance to parents and infection control measures put in place by practices, however Public Health Wales report that current data across the full scope of childhood vaccinations over Qtr 3 has decreased, which may be due to factors affecting service access or service delivery during lockdown.

## Quadruple Aim 2: Infection Prevention

Infection rates per 100,000 have remained relatively stable across the months of the last quarter and the latest position for each the infection types is shown on page 11 of the report along with the position of the other Welsh Health Boards. The favourable position of BCU when benchmarked against the rest of Wales is a demonstrator of the continuing positive work of the Infection Control Team and Estates department.

## Quadruple Aim 2: Mental Health

Adult Mental Health services are seeing a return to pre Covid-19 referral rates and have been able to maintain delivery in compliance of both the assessment and intervention parts of the Mental Health Measure in February 2021. Assessments are at 85.48% compared to 76.32% in the previous month. Interventions are at 87.38% compared to 79.10% in the previous month.

Whilst there is a small improvement in the delivery of assessments and interventions for under 18s, CAMHS are still well below the targets and continue to struggle with delivery of the service to meet the current and recent demand. The capacity issues are linked to staffing and the recovery actions to address these are outlined on page 15 of this report.

Both the number of Mental Health patients experiencing a delayed transfer of care (DToc) and the length of the delay have improved. 12 patient delays are reported in March 2021 compared to 19 in February 2021 resulting in a delay length reduction from 2,963 days in February 2021 to 819 days in March 2021. This has in part been due to a review of the discharge planning for some of the longer term and more complex patients.

Performance against the 26 Week target for children awaiting neurodevelopment assessment remains poor. However, there has been a month on month improvement throughout Qtr 3 and Qtr 4 moving from 19.91% in October 2020 to the current March position of 25.98%. Recovery actions implemented in January have exceeded their delivery projections and are expected to continue to deliver improved performance in the next financial year.

## Quadruple Aim 3: Quality & Safety

We have zero never events recorded in March 2021, an improvement on the single case reported in Qtr 3.

The target for completion of complaint investigations within 30 days is 56.47% against the target of 75% whilst this is a small decrease against the February position it is an improvement on the 12 month average. A number of recovery actions due for a phased start in the new financial year will support the reduction in complaint backlog caused by the pandemic.

## Quadruple Aim 4: Mortality and Timely Interventions

The latest available position for Crude Mortality (under 75 years old) is 1.13% in February 2021 an increase from the previous figure of 1.02%. The 0.11% increase is a direct reflection of the second Covid-19 surge, however our Health Board remain under the All Wales average of 1.44%.

There have been issues with the reporting of Sepsis data following the reporting suspension at the onset of the pandemic, steps are being taken to reinstate the accurate and timely recording on each site.



# COVID-19

## Key Messages

BCUHB first Health Board in Wales to reach 20% of population vaccinated for COVID-19

National Lockdown continues to help prevent spread of COVID-19

Bed plans being reviewed to align capacity to reducing demand

Measure	at 19 <sup>th</sup> April 2021
Total number COVID-19 Vaccinations given BCU HB	525,539
Total number of tests for COVID-19 (cumulative since January 2020)	773,408
% Tests turned around within 24 Hours (Last 7 days)	100%
Average turnaround time (Last 7 days)	3 Hours
Number of results: Positive (cumulative since January 2020)	37,874
% Prevalence of Positive Tests (cumulative since 30 <sup>th</sup> January 2020)	8.8%
Rate of positive cases per 100,000*	4,985.4
Number of (PHW) Deaths - Confirmed COVID-19*	841

Source: BCU IRIS Coronavirus Dashboard, accessed 19th April 2021

\* PHW Coronavirus Dashboard Accessed 19th April 2021 data as at 18th April 2021



- There has been a decline in the COVID-19 incidence rates across all Local Authorities (LAs) in North Wales. Gwynedd and the Isle of Anglesey have the third and fourth highest incidence rates in Wales. All LAs in North Wales are currently below 50 per 100,000. There is a geographical variation in incidence by Middle layer Super Output Areas (MSOAs) across North Wales; however, the number of MSOAs with confirmed cases and the number of cases per MSOA are stable. There has been a decrease in the range of case numbers per MSOA.
- Over the last 7 days, COVID-19 cases has largely been in 10-19 year olds on the Isle of Anglesey; Gwynedd cases have largely been in 30-39 year olds; Conwy in 80-89 year olds; in Denbighshire cases have largely been in 30-49 and 60-69 year olds; Flintshire cases have largely been in 0-9 year olds; and Wrexham cases have largely been in 40-59 year olds.
- Overall GP consultations for suspected COVID-19 have remained stable in the past week.
- There continues to be a number of COVID-19 cases in a range of settings in North Wales, however the number of new incidents appears to be declining.
- Hospital occupancy rates have reduced significantly over previous weeks. Occupancy rates are currently highest in the West, partly driven by the ongoing outbreak at Ysbyty Gwynedd. There is some continuation of community onset admissions. Critical care occupancy has stabilised and there has been capacity at all sites, albeit with increased surge capacity still in place.
- Care home settings are also experiencing reductions in rates of incidence amongst residents and staff, and the number of “red” (closed) homes has fallen to single figures across North Wales. In all care homes the vast majority of residents have now received first and second doses of vaccines.
- Revised scenario planning has been published by Welsh Government (WG) which will assist in forward planning of capacity required for the COVID-19 response over the next months, dependent on a range of variables and assumptions including the efficacy of the vaccination programme, the pace of easing of restrictions, and the degree of compliance with ongoing requirements.

## Quadruple Aim 1: People in Wales have improved health and well-being and better prevention and self management

People will take more responsibility, not only for their own health and well-being but also for their family and for the people they care for, perhaps even for their friends and neighbours. There will be a whole system approach to health and social care, in which services are only one element of supporting people to have better health and well-being throughout their whole lives. It will be a 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

## Key Messages

Essential childhood immunisation services continuing throughout lockdown

Staff Flu vaccination rates the highest ever

## Measures

Period	Measure	Target	Actual	Trend
Q3 20/21	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	$\geq 95\%$	95.50%	↓
Q3 20/21	Percentage of children who received 2 doses of the MMR vaccine by age 5	$\geq 95\%$	93.50%	↑

# Quadruple Aim 1: Flu Vaccination

Period	Measure	Target	Actual
<b>Mar 21</b>	Uptake of the influenza vaccination among 65 and Over	<b>75%</b>	<b>78.15%</b>
<b>Mar 21</b>	Uptake of the influenza vaccination among Under 65	<b>55%</b>	<b>54.25%</b>
<b>Mar-21</b>	Uptake of the influenza vaccination among Staff	<b>60%</b>	<b>70.35%</b>

## Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.

There will be an equitable system, which achieves equal health outcomes for everyone in Wales. It will improve the physical and mental well-being of all throughout their lives, from birth to a dignified end. Services will be seamless and delivered as close to home as possible. Hospital services will be designed to reduce the time spent in hospital, and to speed up recovery. The shift in resources to the community will mean that when hospital based care is needed, it can be accessed more quickly.

## Key Messages

CAMHS struggling to meet demand and waiting times lengthening

Improvement in number of Mental Health beds days lost to Delayed Transfers of Care (DLOC)

Neurodevelopment recovery actions starting to demonstrate improvement

## Top Measures (based on movement up or down)

Period	Measure	Target	Actual	Trend
Feb-21	Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged 18 years & over)	90%	90.74%	↑
Feb-21	Percentage of mental health (Adult) assessments undertaken within 28 days of referral	>= 80%	85.48%	↑
Feb-21	Percentage of therapeutic interventions (Adult) within 28 days of assessment	>= 80%	87.38%	↑

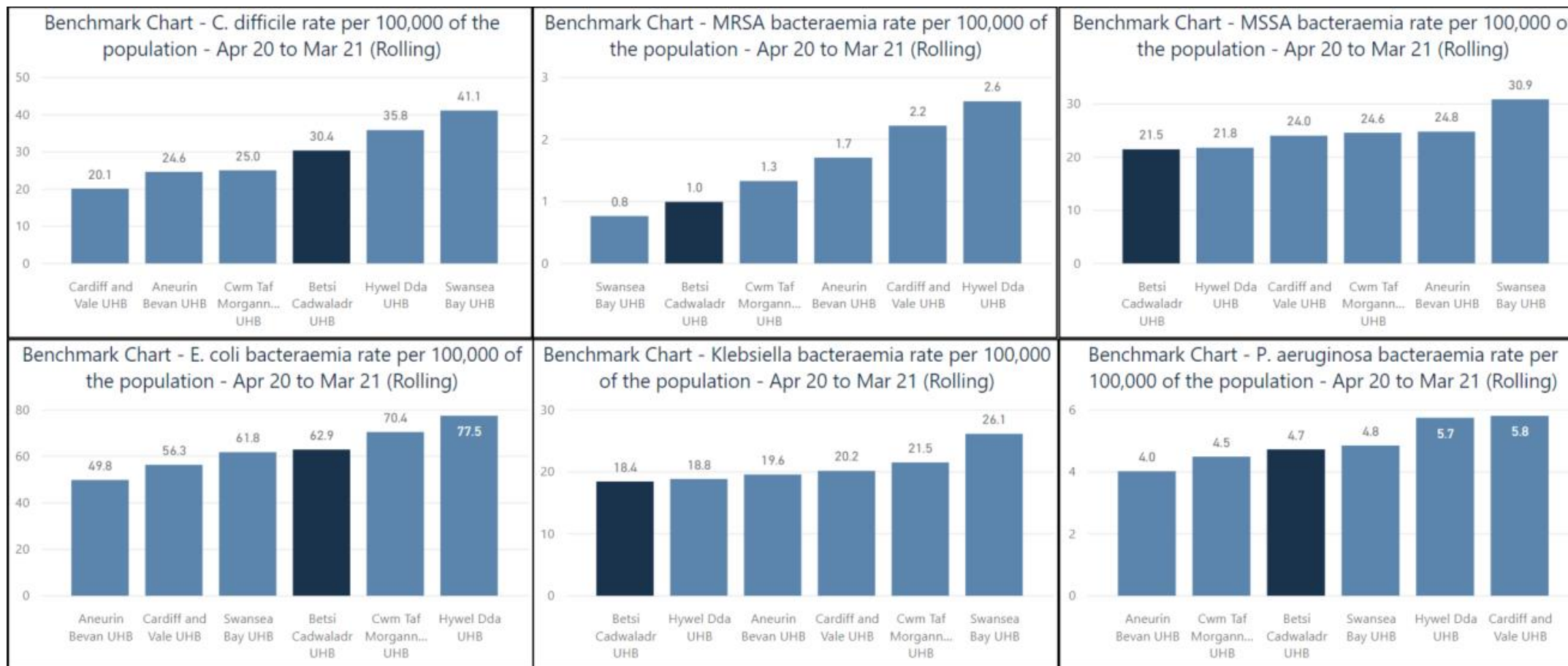


# Quadruple Aim 2: Infection Control Measures

Period	Measure	Target	Actual
Mar-21	Cumulative rate of laboratory confirmed E-Coli cases per 100,000 population	<= 67	63.15
Mar-21	Cumulative number of laboratory confirmed E-Coli cases	N/A	441
Mar-21	Cumulative rate of laboratory confirmed S.Aureus cases per 100,000 population	<= 20	22.77
Mar-21	Cumulative number of laboratory confirmed S.Aureus cases	N/A	159
Mar-21	Cumulative number of laboratory confirmed C.Difficile cases	N/A	212

Period	Measure	Target	Actual
Mar-21	Cumulative rate of laboratory confirmed C.Difficile cases per 100,000 population	N/A	30.36
Mar-21	Cumulative number of laboratory confirmed MRSA cases	0	7
Mar-21	Cumulative number of laboratory confirmed MSSA cases	<= 40	152
Mar-21	Cumulative number of laboratory confirmed Klebsiela cases	<= 38	129
Mar-21	Cumulative number of laboratory confirmed Aeruginosa cases	<= 10	33

# Comparison Charts to all Health Boards in Wales – March 2021



*Rolling period refers to Cumulative April 2020 to Date (March 2021)*

# Quadruple Aim 2: Narrative – Infection Prevention

## Key Drivers of performance

Corrective actions in place and assuring delivery around;

- Pseudomonas outbreak in East critical care
- Covid-19 outbreak within HMP Berwyn
- Tawel Fan Health and Safety Infection Prevention and Control joint review visit following the recent Covid-19 outbreaks
- Covid-19 outbreak in west (Ysbyty Gwynedd and area still ongoing)
- Safe ventilation still an issue across a lot of our estate
- PPE communications is still mainly electronic and could not be reaching key personnel
- Not enough hand washing sinks across the Health Board in the right locations to support pandemic risk reduction
- Infection prevention controls need strengthening across the Health Board to prevent further outbreaks Round one has been received.

## Actions being taken

- We are planning to undertake a table top confirm and challenge meeting with each accountable area around their submitted evidence
- All accountable areas have been asked to reflect on their self assessment and strengthen their infection prevention plan on a page as required
- Key positions to support infection prevention e.g. Antimicrobial pharmacist, infection prevention team members recruitment still in process impacting upon specialist infection prevention support required across the Health Board, we need to retrieve our secondments or back fill rapidly
- Outbreak management is in place for YG to strengthen the controls

## Risk

- Two care homes in the West experiencing significant increasing Covid-19 numbers causing concern additional supporting is being provided.
- Increased linked case in one learning disability house, clear learning and actions in place
- Two mental health facilities increase in staff cases issues addressed re face masks and social distancing

# Quadruple Aim 2: Narrative – Infection Prevention

## Need

- To have a IT solution for monitoring antibiotic use enabling rapid audit and escalation when off guidance
- An IT solution for tracking MRSA screening at front door and in hospital at 30 days and MSSA screening in our renal patients
- To introduce a database to support data capture, good governance and learning
- Junior doctors audits around antimicrobials start then focus still needs strengthening very poor uptake to date
- Antimicrobial high usage in the community need to develop a support plan to reduce over the coming months
- More isolation availability is needed particularly in our community hospitals, Ysbyty Gwynedd and Wrexham Maelor is a significant issue hampering our ability to keep our patients safe this has been added to the Board Assurance Framework
- Decant areas to undertake routine HPV cleaning to reduce bio burden across the health Board this has progressed through still need
- Care bundles and risk assessments for patients completed and checked daily this needs to be reviewed daily to support completion
- Patient Infection Review to be undertaken rapidly within 72 hours to ensure safety and learning is quickly embedded
- Reinforcement of Catheter appropriateness and management
- To develop regular monitoring around numbers and care bundle compliance



# Quadruple Aim 2: Mental Health Measures

Frequency	Measure	Target	Actual	Trend
Feb-21	Percentage of mental health (Adult) assessments undertaken within 28 days of referral	$\geq 80\%$	85.48%	↑
Feb-21	Percentage of therapeutic interventions (Adult) within 28 days of assessment	$\geq 80\%$	87.38%	↑
Feb-21	Percentage of mental health (CAMHS) assessments undertaken within 28 days of referral	$\geq 80\%$	32.05%	↑
Feb-21	Percentage of therapeutic interventions (CAMHS) within 28 days of assessment	$\geq 80\%$	22.41%	↑

Frequency	Measure	Target	Actual	Trend
Mar-21	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	$\geq 80\%$	25.98%	↑
Mar-21	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	$\geq 80\%$	59.18%	↑
Mar-21	Total Number of mental health delayed transfer of care (DToC) patients	Reduction	12	↑
Mar-21	Total Number of mental health delayed transfer of care (DToC) bed days	Reduction	819	↑

# Quadruple Aim 2: Narrative – Children & Young Adult Mental Health Services (CAMHS)

## Children and Young Adult Mental Health Services (CAMHS)

### Key Drivers of performance

- Increased acuity and reduced efficacy of evidenced based treatments delivered remotely leading to increased new to follow up ratio
- Reduced capacity within the teams partially due to turnover into new roles – the current vacancy rate stands at 24.94%
- Reduced physical capacity within CAMHS accommodation due to social distancing requirements
- IT hardware not available for all staff to support remote working

### Actions being taken

- Assessment and therapy capacity increased for each team through procurement of private provider – additional Single Tender waivers being completed
- Tender for private provider for assessments and therapy to be renewed, Ministerial approval to be sought – awaiting Executive approval to proceed
- Workforce plan to be completed to include recruitment strategies for all groups, additional support requested for HR
- Funding secured via Children's Services plan for recruitment of Psychiatry trainees for each Area
- HEIW allocated one training number for commencement in August 2021. A further two training numbers requested for 2022/23
- Attend Anywhere being utilised in all teams – video contacts constituted 18.14% of total attendances in February, increasing month on month
- Requests for additional IT hardware escalated to Area teams, IT have advised further laptops will be available in April/May
- Ongoing discussions regarding access to additional accommodation for clinical contacts including discussions with schools to support remote appointments
- Thirteen Family Wellbeing Practitioners appointed and in post across the teams – one post outstanding. Will be a post in each GP cluster
- Recruitment from Service Improvement funding underway for Crisis Services and Eating Disorder Services.
- Improvement funding–bids submitted for private provider provision, transformation and business support, development posts, Health Care Assistants (HCAs), Assistant Psychology support
- Recovery plan developed including trajectories and actions to be reviewed monthly in CAMHS Performance and Improvement Group

### Timelines

- Tender process to be completed with contract in place by October 2021
- Workforce plan to be finalised, dependent on additional support from HR and with additional funding from Welsh Government, timeframe to be confirmed.
- Emergency Department posts to be recruited to by the end of April, Crisis post by end of July, subject to successful recruitment

### Risk

- Current vacancies and additional posts cannot be recruited to - to be supported by workforce plan
- Demand for services likely to increase when schools return – Family Wellbeing Practitioners to support with demand management
- Non-delivery on MHM targets included on service risk register – reviewed regularly at local meetings

# Quadruple Aim 2: Narrative Neurodevelopment

## Neurodevelopment

### Key Drivers of performance

- Waiting list continues to grow inline with expectation, currently 2169 an increase of 37 on the February position. Longest wait is at 194 weeks the family have now declined 3 appointments with our provider partners, the area team is engaging with them to find a solution. As of Mar 21 our waiting list for < 26 weeks is 559 (+ 41); over 12 months is 1,325 (+51), over 24 months 498 (-9) and over 36 months 41 (+6)
- Referrals remain at 75-80% of pre Covid19 level, there has been a slight increase in the last couple of weeks which may be due to some schools opening, Accepted referrals remain unchanged at 55-60% which is lower than pre Covid19 (5-10% lower) which is a combination of increase of referrals not meeting the NICE guidance or repeated failure to supply additional information.
- Activity from within establishment remains below trajectory but has increase since last month and is now at 50-55% of pre Covid19 levels and we hope to see that increase over the next couple of months.

### Actions being taken

- External provider commenced in January and is achieving its projections. They have now provided us with a new projection of an increase in capacity within a shorter period. Simply put they have offered 1700 assessments commenced by March 2022. this compares with the original offer of 1500 completed within 24 months.  
Additional tender being changed to reflect the above and to now look at support post waiting list recovery and intervention required post assessment.
- Identification of cost pressure to complete the waiting list recovery and lost of activity to Covid19 submitted regionally (£1.45 million) as part of planning processes for 2021/22
- Recruitment program continued

### Timelines

- Internal capacity aimed to be pre COVID19 level by Qtr1 2021/22. The impact of the new projection on internal capacity identified and planned for by Qtr1.
- New Projection can only be financially supported for the first two Qtrs and we await outcome of the executives decision on the current submission.
- New tender to be finished and seek approval for submission in Qtr. 2  
New graduates likely to come on stream in Qtrs 2/3 2021/22 with additional staff in the mean time replace natural turnover within services

### Risk

- Achieving the new projection will require significant commitment of current staff in post for a9-12 month period which will impact other areas of the service, this is currently being reviewed by the areas with contingency plans being finalised by Qtr. 1.
- Future demand following full opening of all schools likely to see referral increase, working with Local Authority schools to improve clarity regarding expectation and appropriateness of referrals. (Department risk register to reflect local position with individual Local Authority)
- Cost pressure funding for the waiting list recovery not supported: Current projections are without additional funding and capacity Waiting List recovery will not be possible. (Divisional risk)

# Quadruple Aim 2: Narrative – Adult Mental Health Delayed Transfers of Care (DToC)

## Delayed Transfers of Care (DToC)

### Key Drivers of performance

- Weekly divisional scrutiny panel, supported by Heads of Nursing (HONs) and senior staff, Continuing Health Care (CHC) and finance.
- \* Analysis of weekly figures, barriers to change, appropriate coding of registration, actions and reduction/ increase in DTOC for that period.
- National database updated and all related training given, this is now single source of DTOC information, to allow parity and consistency across division.
- Expected Discharge Date (EDD) requested for all registrations to allow monitoring of process and appropriate actions.

### Actions being taken

- Policy and process reviewed to ensure accuracy and consistency across BCUHB Mental Health and Learning Disabilities Division
- Divisional scrutiny panel weekly data considered, barriers identified and support and guidance offered by panel members.
- Draft report completed of Delayed Transfer review with recommendations. Awaiting comments and scrutiny from Command meeting.
- Significant reduction in registered DTOC's since scrutiny process, enabled 50% + reduction noted, to date.
- Since the review commenced we have reduced bed days lost to DTOC from 3000 to 789 at the end of March.

### Timelines

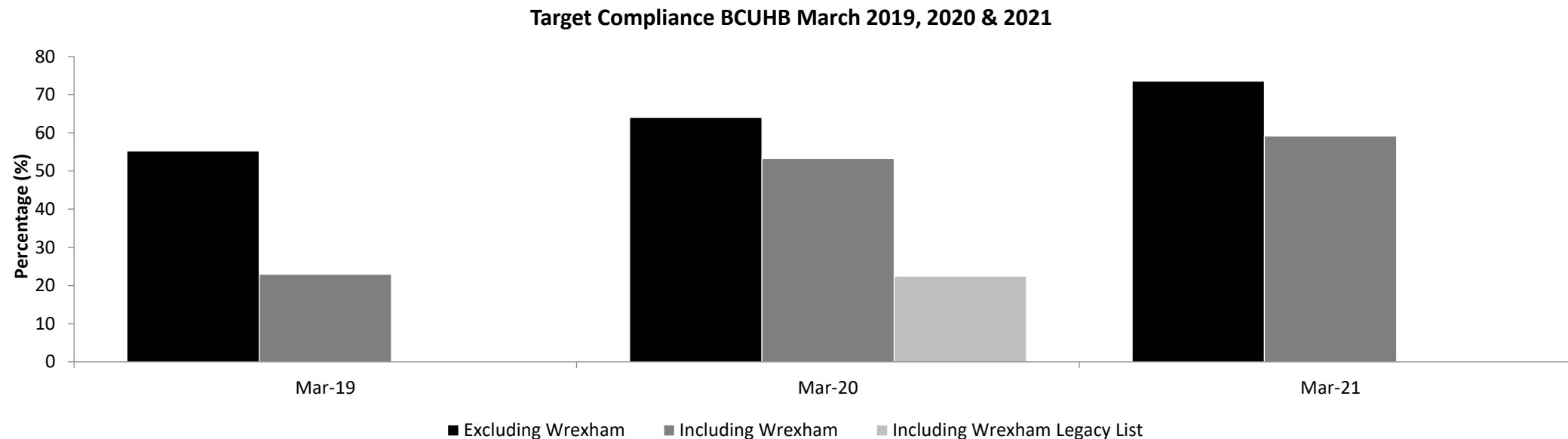
- National database updated weekly, followed by scrutiny and recommendations. Process enabled 5.2.21 and ongoing.
- Scrutiny panel supported by HONS, CHC and Finance, continues weekly to date.
- Draft report of review of Delayed Transfer completed March 2021. Awaiting feedback and comments before finalising and distributing.

### Risk

- All risks managed through weekly scrutiny panel review and reported to divisional leads with mitigation plans. Timelines, and EDD's.
- All significant barriers identified and reported to Command meeting, where additional senior support is identified, as a need to ensure timely resolution.

# Quadruple Aim 2: Narrative – Adult Psychological Therapy

## Secondary Care Specialist Psychological Therapy: % patients seen referral to treatment in 26 weeks



### Note to chart

- Position has been shown excluding and including Wrexham to highlight performance issue specific to the Wrexham service.

### Key Drivers of performance

- Improved Access to Psychological Therapies for North Wales Adults
- Implementation of Matrics Cymru (Welsh Government guidance on the stepped care model for provision of psychological therapies across NHS Wales services).
- WG Compliance Target for secondary care Acute Mental Health specialist level interventions - % seen in 26 weeks

# Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable




## Key Messages

Roll out of early concerns resolution work has commenced

All Wales Review Tool for Pressure Ulcers now available on Datix

Additional Well-Being resources provided for staff

## Measures

Period	Measure	Target	Actual	Trend
Mar-21	Percentage of complaints that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the complaint was first received by the organisation	75%	56.47%	
Mar-21	Number New Never Events	0	0	
Mar-21	Doctor Appraisal / revalidation rate*	95%	74.58%	

Failure to complete an appraisal due to COVID-19 issues will be logged as an approved missed appraisal. Everyone who has not completed an appraisal so far in 2020 is entitled to an approved missed appraisal. The adjusted figures should read 100% for all areas

New models of care will involve a broad multi-disciplinary **team** approach where well-trained people work effectively together to meet the needs and preferences of individuals. Joint **workforce** planning will be in place with an emphasis on staff expanding generalist skills and working across professional boundaries. Strategic partnerships will support this with education providers and learning academies focussed on professional capability and leadership.



# Quadruple Aim 4: Narrative – Serious Incidents

## Serious Incidents (Welsh Government Reportable)

### Key Drivers of performance

- Key performance indicators set by Welsh Government (criteria narrowed as of 05 January due to conflicting pressures of COVID 19)
- BCUHB core values: Putting Patients First
- Putting Things Right (PTR) Regulations

### Actions being taken and timelines

- Daily incident review meeting in place
- Local daily safety huddles in place
- Phased testing and implementation of new process for incident and serious incident management – rolling out in April 2021
- Introduction of Serious Incident Learning Panel – rolling out in April 2021
- Introduction of new incident investigation skills passport – finalising in April 2021
- New Datix system planned for implementation – launch on 01 July 2021

### Impact upon performance should be visible by:

- Reduction in time taken to report to Delivery Unit /Welsh Government  
(target = 90% reported within 24 hours / March performance = 50%, highest ever achieved )
- Improvement in completion time of SI investigations  
(target = 90% completed within 60 working days / March performance = 56.10%, reduction from prior month but improvement on the 12 month average)

### Risk

- Services continue to report issues identifying staff as Investigating Officers, causing delays in commencement of investigation and cancellations of Serious Incident Reviews
- The quality of investigations is variable
- The level of patient and family involvement in investigations is variable
- The recent COVID 19 second wave has created a backlog of overdue serious incidents (33 as of March 2021)

## Falls, HAPU and Medication Errors Reported as Serious Incidents

### Key Drivers of performance

- Key performance indicators set by Welsh Government (criteria narrowed as of 05 January due to conflicting pressures of COVID 19)
- BCUHB core values: Putting Patients First
- Putting Things Right (PTR) Regulations

### Actions being taken and timelines

- Daily incident review meeting in place
- Local daily safety huddles in place
- Falls and HAPU dashboards in place to provide local access to data and trends
- Strategic Falls Group re-commenced with a focus on accurate and consistent data and reporting to support identification of themes and areas for improvement
- All Wales Review Tool for Pressure Ulcers now available on Datix and being tested to provide easier data collection and theming – launched 01 April
- SI investigations for all falls/HAPUs and Medication Errors which will be scrutinised at the new Serious Incident Learning Panel – rolling out in April 2021

### Risk

- Prior to the introduction of the DATIX All Wales Review Tool for Pressure Ulcers, forms were completed manually on paper and filed locally

### HAPU Data:

- 524 Grade 3, 4 and unstageable reported in Q4. Of the 388 closed in same quarter, 20 were deemed avoidable (serious incidents)

### Falls Data:

- 25 patient falls with harm were reported in Q4 (4 in Ysbyty Gwynedd, 3 in Ysbyty Glan Clwyd, 3 in Wrexham Maelor, 5 in Mental Health and Learning Disability services, 3 in community hospitals)

### Medication Error Data:

- 1 medication error was reported as a Serious Incident in Q4 Wrexham Maelor



# Quadruple Aim 4: Narrative – Complaints

## Complaints

### Key Drivers of performance

- Key performance indicators set by Welsh Government (criteria narrowed as of 05 January due to conflicting pressures of COVID 19)
- BCUHB core values: Putting Patients First
- Putting Things Right (PTR) Regulations

### Actions being taken and timelines

- Weekly meetings in place across services
- Improved joint working between Complaints Team and PALS to address complaints through Early Resolution
- Pilot of a Matron Helpline being setup and tested at WMH – to commence in April/May 2021
- Phased testing and implementation of new process for complaints – rolling out in April 2021
- Introduction of new complaint handling/investigation skills passport – finalising in April 2021
- Ombudsman delivered training rolling out – April 2021
- New Datix system planned for implementation – launch on 01 July 2021

### Impact upon performance should be visible by:

- Improvement in time taken to report to acknowledge complaints  
(target = 95% acknowledged within 2 working days / March performance = 100%, highest ever achieved )
- Improvement in completion time of complaint investigations  
(target = 75% completed within 30 working days / March performance = 56.47%, reduction from prior month but improvement on the 12 month average)

### Risk

- Services continue to report issues identifying staff as Investigating Officers causing delays in commencement of investigation
- The quality of investigations is variable
- The level of patient and family involvement in investigations is variable
- The recent COVID 19 second wave has created a backlog of overdue complaints (130 as of March 2021)

### What are the top 3 reasons concerns are raised? Which Site/Area has most concerns raised and for how long?

- 1. Communication: 1,126 for 2020. 2. Clinical Treatment/Assessment: 649 for 2020. 3. Appointments: 553 for 2020.
- The number of complaints including early resolution (previously known as On The Spots) per site continually fluctuates with East and Central having the highest numbers. For 2020: East 1517, Central 1345 and West 1022

# Quadruple Aim 4: Narrative – Learning from Never Events

## Never Events

There were no Never Events reported in Q4.

The independent review of a never event in urology services was received and an assessment made of the findings against the internal investigation action plan. One area has been identified for further work which is the development of human factors capability. This is being taken forward by the Corporate Patient Safety Team and a multi disciplinary working group, under executive leadership of the Executive Medical Director.

**Quadruple Aim 4:**  
Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation enabled by data and focussed on outcomes.

Delivering higher value in health and social care will focus on outcomes that matter to the individual and making our services safe, effective, people centred, timely, efficient and equitable. This will bring individuals to the fore and consider the relative value of different care and treatment options, in line with Prudent Health. Research, innovation and improvement activity will be brought together across regions - working with RPBs, universities, industries and other partners. Alignment of funding streams and integrated performance management and accountability across the whole system will be in place to accelerate transformation through a combination of national support, incentives, regulation, benchmarking and transparency.

## Key Messages

Covid related admissions contributing to Mortality Rate increase

Increased system working to link Health and Social Care Data

North Wales COVID-19 Protection and Response Plan Produced

## Measures

Period	Measure	Target	Actual	Trend
Feb-21	Crude hospital mortality rate (74 years of age or less)	Reduction	1.13%	↓
Mar-21	Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Improve	No Data	
Mar-21	Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Improve	35.71%	↓
Jan-21	Percentage of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours	>= 75%	60.00%	↓
Mar-21	Percentage of episodes clinically coded within one reporting month post episode discharge end date	>= 95%	93.90%	↑

# Quadruple Aim 4: Narrative - Mortality

## Mortality

The 12 month rolling crude mortality rate for ages 75 years and under is below the All Wales average (1.13% v 1.44% (All Wales) February 2021). This has increased during the last quarter in line with the second COVID-19 surge (+0.11%) as seen across All Wales (+0.19%). The highest number of deaths was in those patients admitted with COVID-19, pneumonia, sepsis, stroke, heart failure and COPD.

## Key Drivers of performance (for February 2021 against the All Wales Peer Group reported by CHKS)

- Crude mortality- overall (2.57% v 3.04%) this is similar to the level seen last June when the first surge abated
- Mortality- sepsis (17.8% v 43.2%) the very high peer group average is most likely due to coding issues; the BCU data is fairly consistent
- 30 day mortality- stroke (14.5% v 19.1%) reduced compared to previous month; highly variable month on month due to small numbers with as tendency to be below the peer

## Actions being taken

- Implementation of DATIX mortality module to support learning from deaths remains on course. There is some changes required to enhance usability.
- The roll out of the Medical Examiner has been delayed until we can provide scanned notes; funding has been agreed and the recruitment process has started. This will support our decision to undertake further review and highlight any emergent themes for action.
- Process for identifying and learning from Hospital Acquired COVID-19 cases has been developed with the acute sites; additional support is required and a paper will be developed to support this.
- Work is in progress to appoint a secondary care mortality lead to work with OMD to increase local ownership and enhance learning.
- Supporting Delivery Unit with developing All Wales Learning from Deaths Framework. This will inform our developing policy (update delayed due to capacity issues)

## Timelines

- DATIX mortality module – aim to be paperless for in-patients by April 2022. Acute site roll out complete by August 2021; Community beds by April 2022.
- Medical Examiners– aim all deaths on acute sites will be scanned by August 2021. Process currently being tested with small number from Ysbyty Gwynedd and Wrexham Maelor.
- Health Care Associated Infections (HCAI) COVID-19 deaths - Sites have lists of all deaths for review; process in place to update monthly. Review process has started to roll out on all sites. Completion date will depend on resources available and cannot be confirmed at this time. This will be discussed at April CEG meeting.
- Secondary Care Lead - Job description written and for approval with EMD before advertising post – aim to be appointed by July 2021
- Learning from Deaths Policy – update to be drafted by June 2021

## Risk

- The COVID-19 pandemic has reduced the capacity for staff to undertake routine mortality reviews; leading to a backlog of stage 2 reviews, increased significantly by HCAI death reviews. Additional resources will be required to ensure these are completed. This position is similar to other Health Boards in Wales. Failure to complete these in a timely way may impede safety and also cause reputational damage to the Health Board. A proposal is being written for Executive review.

# Quadruple Aim 4: Narrative – Timely Interventions - Sepsis

## Sepsis Six in Emergency Departments

- Why is the compliance with sepsis six in our EDs so low?  
There has been a significant reduction in collecting data across all sites. The limited information available is insufficient to be confident about performance.
- Is there an outlier or is it similar across BCU?  
Data capture is an issue on all sites
- What is being done to improve performance against this measure?  
Wrexham Maelor Hospital (WMH) are inputting the data already captured to establish their current baseline.  
Ysbyty Glan Clwyd (YGC) is auditing currently to establish their baseline

## Key Drivers of performance

- % compliance with sepsis 6 inpatients excluding Intensive Care - no data reported
- % compliance with sepsis 6 emergency departments- 35% (March 2021)

## Actions being taken

- WMH - they have a number of paper Sepsis 6 record that require inputting into the electronic system. The Hospital Management Team (HMT) have advised this is now being addressed (as of mid April).
- First meeting of the “Managing Acutely Ill Patient (MAIP) group” has taken place. The group will identify the improvement opportunities including sepsis once the baseline data are available to them. A job description and report is in preparation to support a temporary improvement post for managing acute deterioration to support delivery of education, leadership for the, sepsis quality improvement work and better management of the data pathway etc.– this will be presented to HMT for approval.
- Ysbyty Gwynedd (YG) – reinstate the deteriorating patient group to agree the improvement work including sepsis.
- YGC – Emergency Department (ED) have completed an audit in March 2021 and are meeting to discuss findings when will share improvement opportunities at ED clinical governance meeting. Planning to launch new documentation with evaluation (Plan Do See Act cycle)

## Timelines

- WMH - Data analysis – date to be confirmed (resource dependent). Post - July 2021 to go to advert. MAIP to report to site Clinical Effectiveness Group (May 2021)
- YGC – ED improvement plan (May 2021) ; trial new pathway starting May 2021; evaluation June 2021
- YG – Improvement plan date to be agreed with Site Medical Director

## Risk

- The significant reduction in Sepsis 6 audit follows the suspension of this requirement during COVID-19 surge nationally. This has not been reinstated robustly and so current performance is not assured. However, mortality has not deteriorated and we remain below the All Wales peer average. The risk is an increase in mortality and morbidity from sepsis that is not recognised. There is also a reputational risk to BCU if mandatory reporting does not occur. Actions – all sites are aware of the need to robustly reinstate this and improvement groups are in different stages of set up to move this forward. Regular reporting to Secondary Care Clinical Assurance Group will commence.



# Quadruple Aim 4: Narrative – Timely Interventions – Orthogeriatrician Review

## Timely Interventions

### Key Drivers of performance

- % hip fracture patients who receive Orthogeriatrician review within 72 hours, for March 2021 –Ysbyty Glan Clwyd 100% (No change);Ysbyty Gwynedd 72.4% (Was 74.1%) ;Wrexham Maelor Hospital 68.7% (was 72.2%)

### Orthogeriatrician Review within 72 Hours

- How can we improve performance against this measure?

From the National Hip fracture database the All Wales average for this is 60% (90% across the UK).

Wrexham Maelor –The improvement already seen has been due to working patterns including the Department of Medicine for the Elderly providing 4 planned ward rounds each week. Additional resources are required to further improve this to provide cover for holidays and planned leave.

- Do we have Orthogeriatricians on all Acute sites?

Yes services are in place on all sites

## Sepsis Six Compliance: Emergency Department

Emergency	April 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Total
The number of patients identified as positive to sepsis screening requiring a new response in a 24 hour period	48	47	86	103	86	105	116	82	48	44	36	28	829
Number who received all six elements of the sepsis bundle within 1 hour	23	26	37	53	40	55	54	39	22	27	10	10	396
% compliance	47.92	55.32	43.02	51.46	46.51	52.38	46.55	47.56	45.83	61.36	27.78	35.71	47.77
Number of patients who received a positive screening for sepsis but did not receive a diagnosis of sepsis	6	1	3	3	1	1	1	3	1	2	3	1	26

## Sepsis Six Compliance: Inpatients

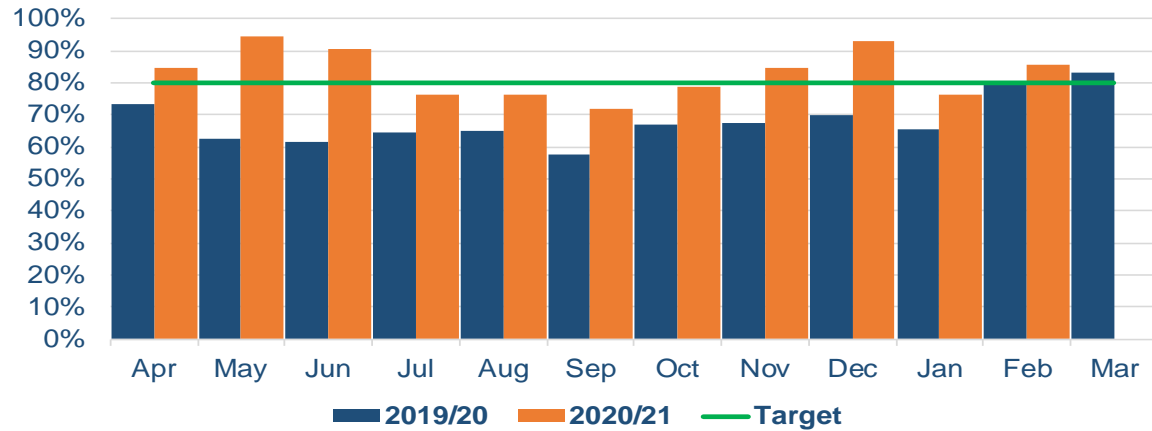
Inpatients (excluding patients currently in critical care beds)	April 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Total
The number of patients identified as positive to sepsis screening requiring a new response in a 24 hour period	24	37	26	0	0	0	0	0	0	0	0	0	87
Number who received all six elements of the sepsis bundle within 1 hour	24	37	26	0	0	0	0	0	0	0	0	0	87
% compliance	100	100	100	no data	no data	no data	no data	no data	no data	no data	no data	no data	100
Number of patients who received a positive screening for sepsis but did not receive a diagnosis of sepsis													0

# Additional Information

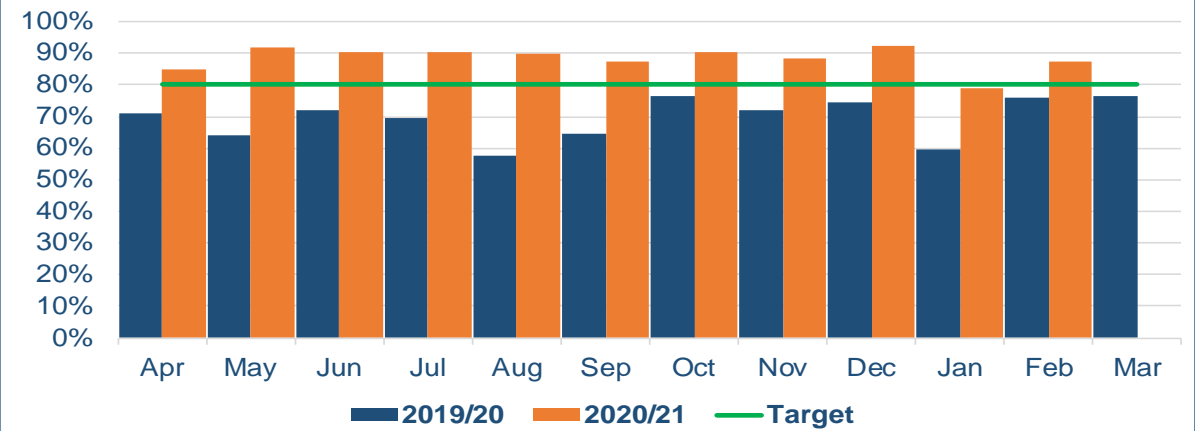


# Quadruple Aim 2: Charts Adult Mental Health

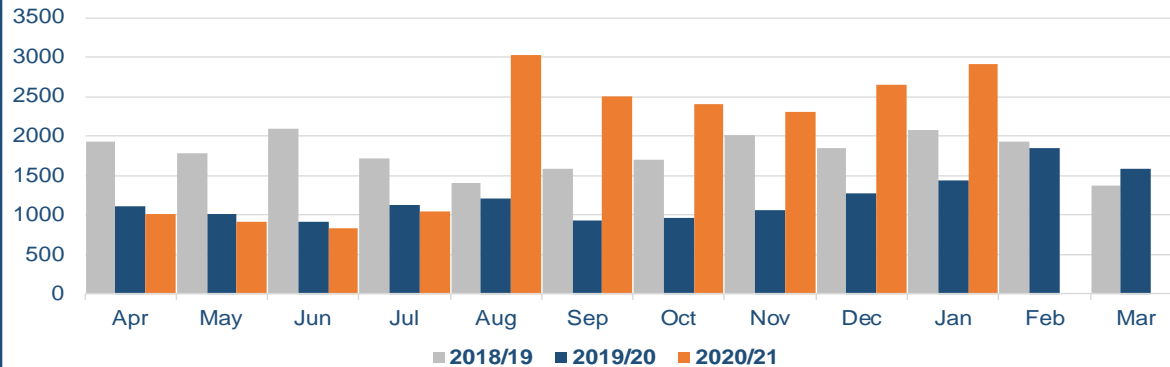
**Percentage Mental Health Assessments (Adult) within 28 days of Referral**  
2019/20 vs 2020/21 (February 2021)



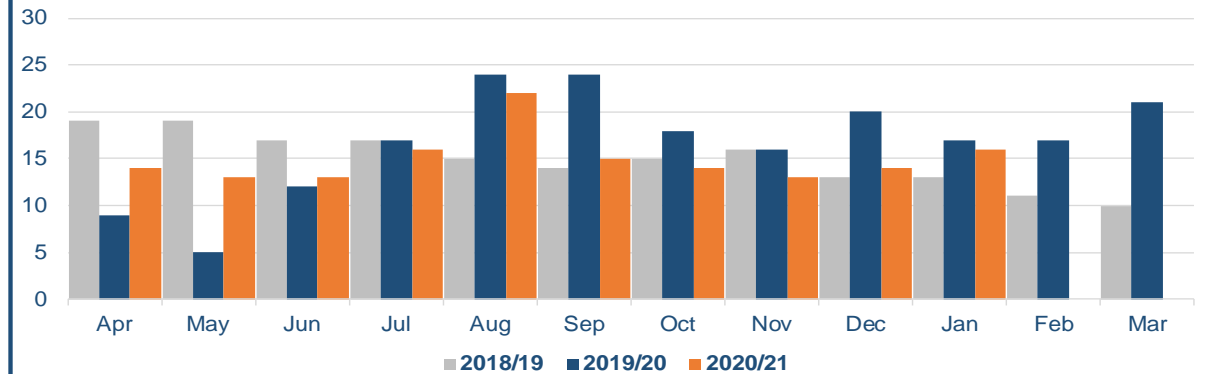
**Percentage Mental Health Therapeutic Interventions (Adult) within 28 days of Assessment**  
2019/20 vs 2020/21 (February 2021)



**Number of Delayed Bed Days (BCU Mental Health)**  
2020/21 comparison to 2018/19 and 2019/20  
January 2021



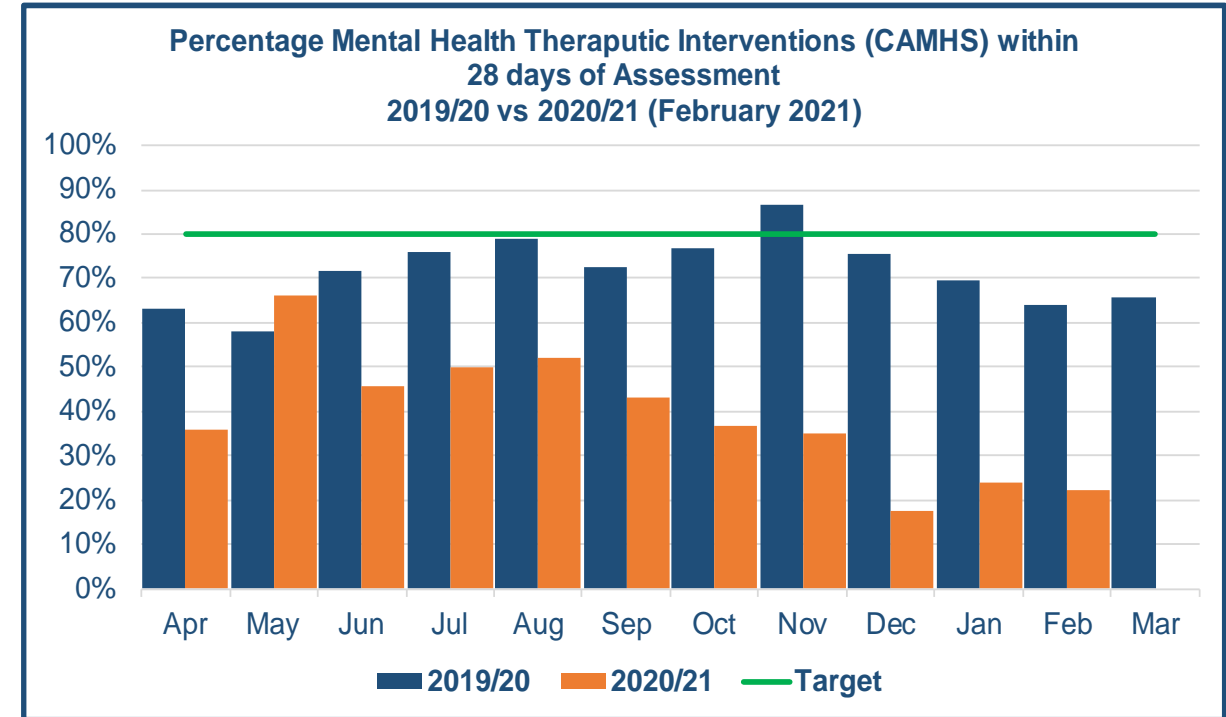
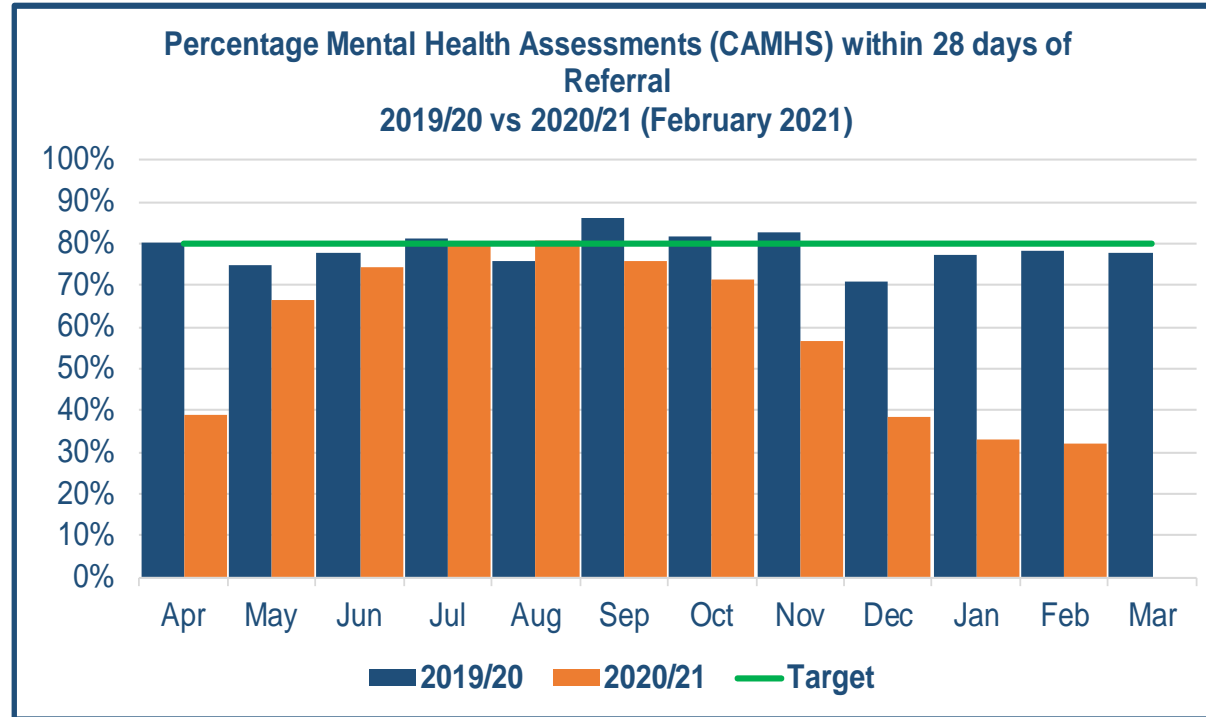
**Number of Delayed Patients (BCU Mental Health)**  
2020/21 comparison to 2018/19 and 2019/20  
January 2021



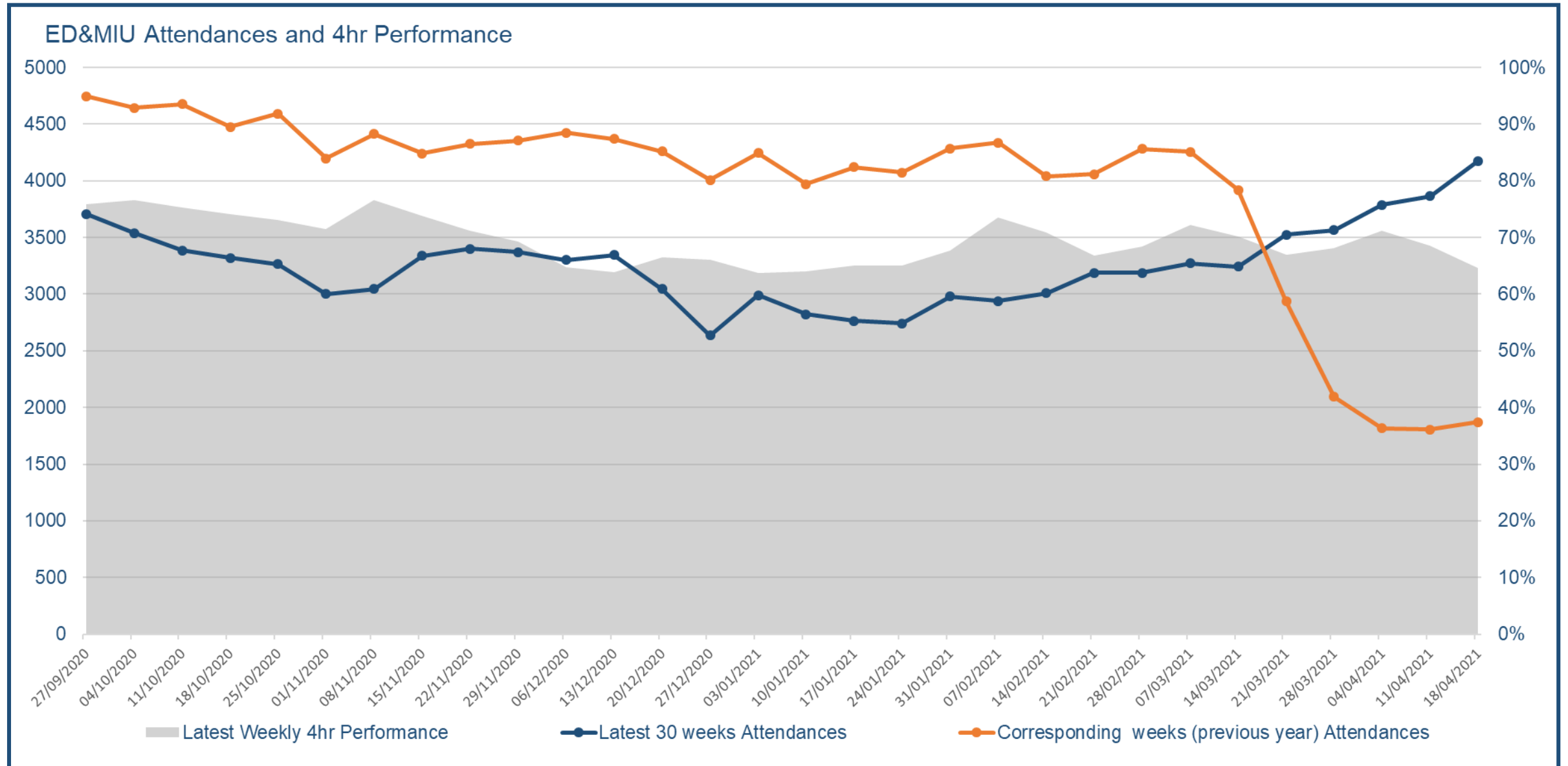
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1926	1780	2093	1715	1407	1584	1704	2008	1843	2083	1932	1365
2019/20	1110	1004	917	1121	1210	927	958	1064	1275	1445	1840	1578
2020/21	1015	921	837	1042	3025	2501	2400	2312	2649	2913		

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	19	19	17	17	15	14	15	16	13	13	11	10
2019/20	9	5	12	17	24	24	18	16	20	17	17	21
2020/21	14	13	13	16	22	15	14	13	14	16		

# Quadruple Aim 2: Charts CAMHS



# Impact of Covid-19 Pandemic on Unscheduled Care



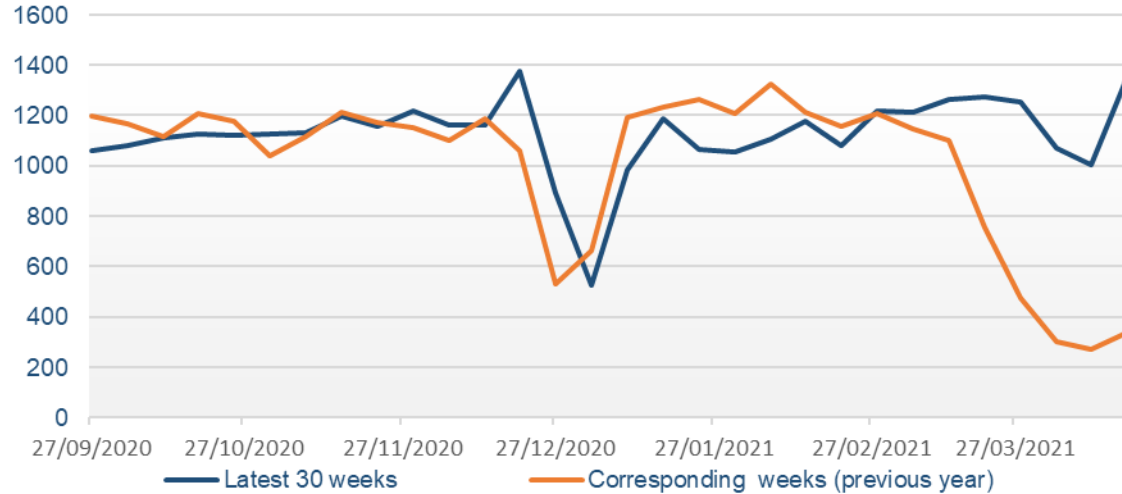
# Impact of Covid-19 Pandemic on Unscheduled Care

Position as at end of 18th April 2021	Dec 20	Jan 21	Feb 21	Mar 20	Mar 21	April 1st - 18th 2020	April 1st - 18th 2021
ED&MIU 4 Hour Performance	64.28%	65.80%	69.81%	76.05%	69.21%	91.24%	<b>67.98%</b>
ED 4 Hour Performance	57.10%	59.29%	63.43%	68.33%	62.61%	89.90%	<b>61.09%</b>
ED 12 Hour Performance	1751	1878	1561	938	1618	12	<b>1083</b>
1 - 2 Hour Ambulance Handover	503	482	479	228	523	12*	<b>353*</b>
2 - 3 Hour Ambulance Handover	256	259	218	64	243	3*	<b>197*</b>
3 - 4 Hour Ambulance Handover	143	145	114	17	111	0*	<b>63*</b>
4 - 5 Hour Ambulance Handover	63	81	47	8	36	0*	<b>17*</b>
Over 5 Hour Ambulance Handover	61	61	26	3	26	0*	<b>3*</b>
Red 8 Minute	61.12%	55.29%	63.68%	70.46%	61.78%	70.56%	<b>55.18%</b>

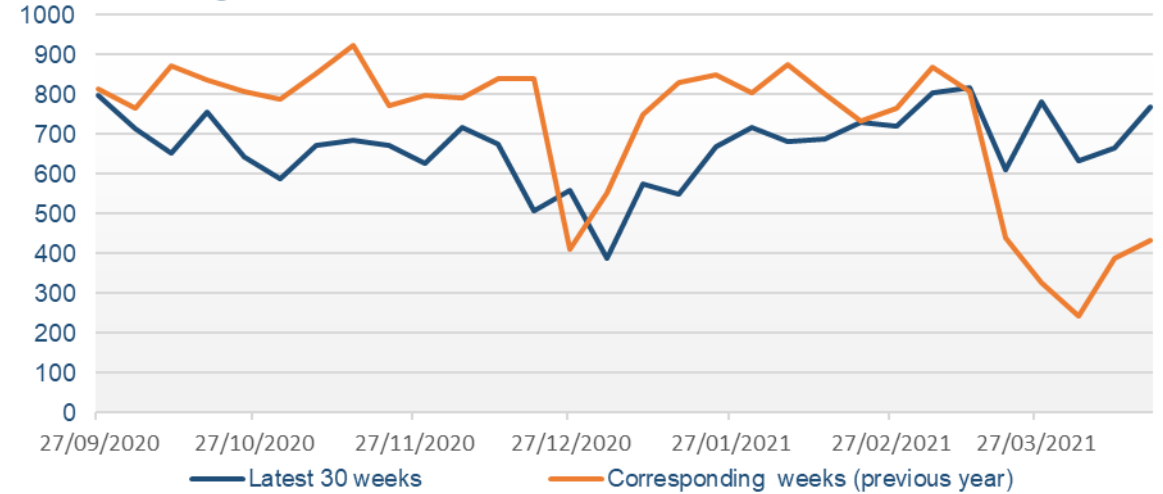
\*Please note: WAST Handover data is 1 day in arrears so the April positions are 1st to 17th  
Red 8 Minute data is unvalidated and not for sharing outside this report.

# Impact of Covid-19 Pandemic on Referral Rates

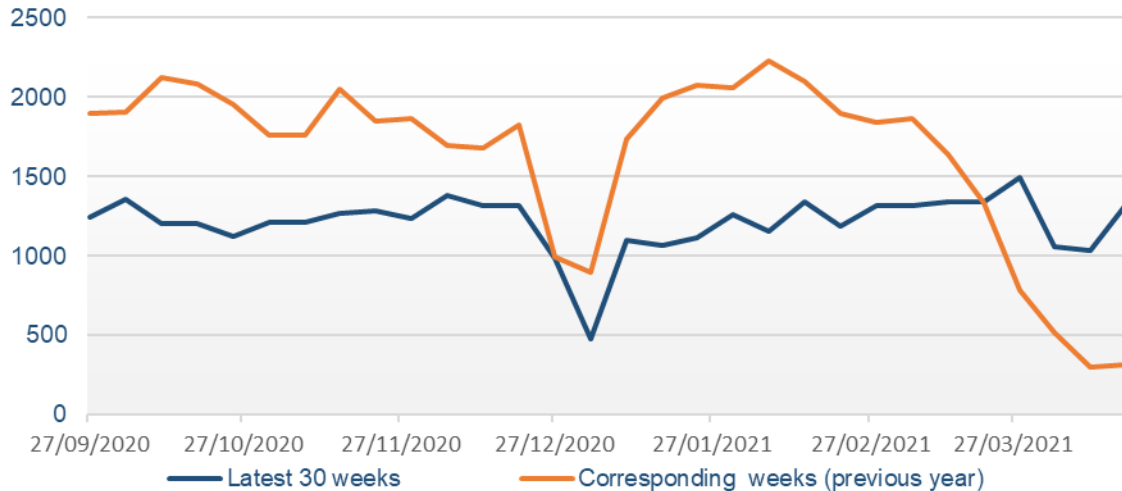
## GP Urgent



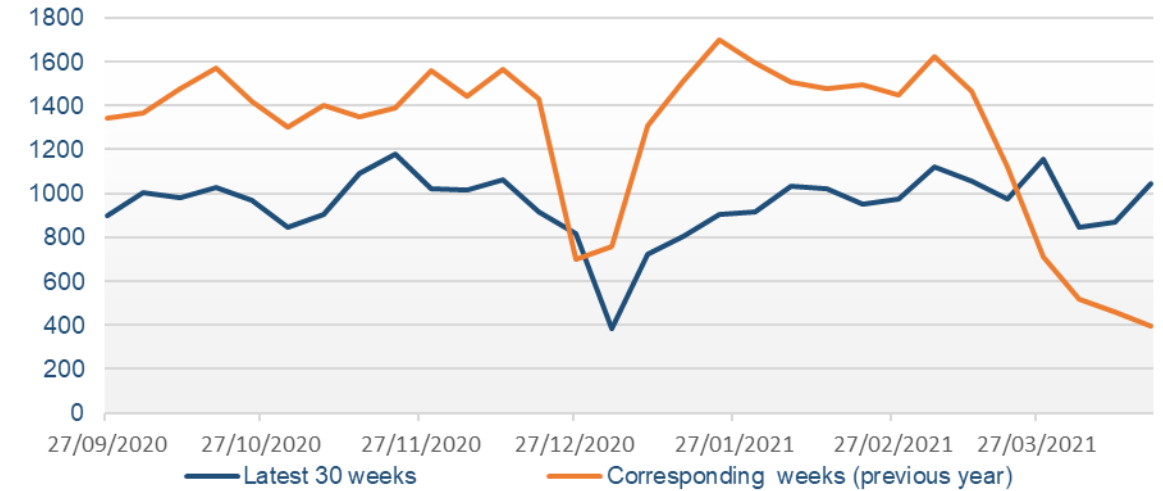
## Non-GP Urgent



## GP Routine

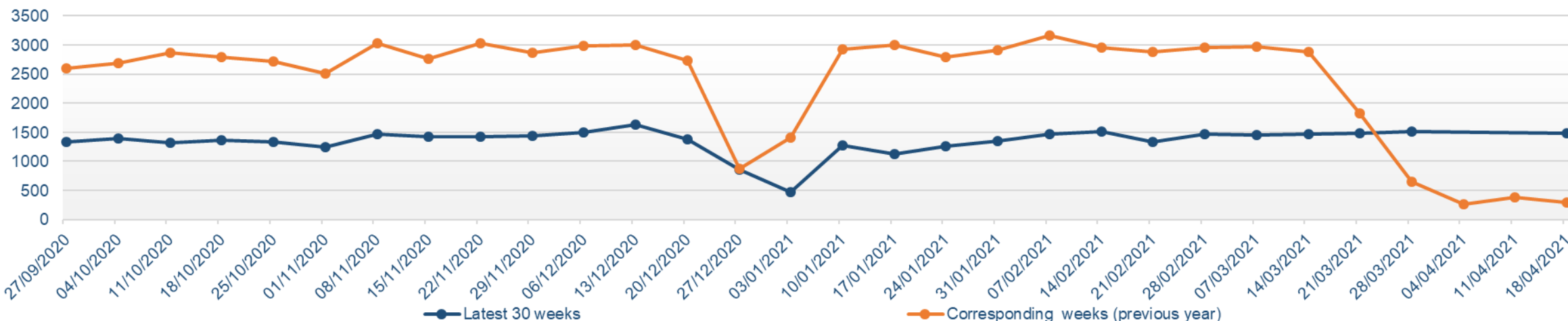


## Non-GP Routine

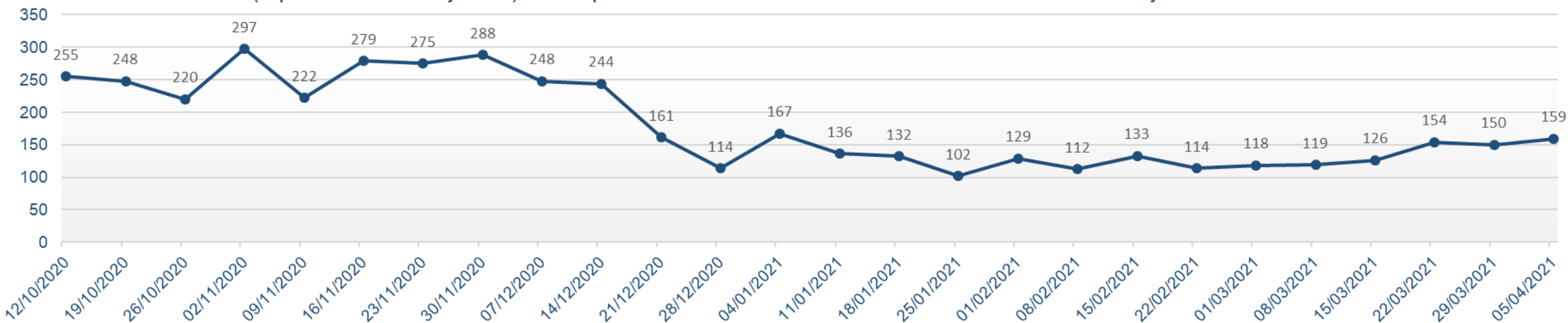


# Impact of Covid-19 Pandemic on Planned Activity

RTT High Level Report - Core Outpatient Activity (new, RTT, face to face attended appts)



Theatre Procedures (Inpatient and Daycase): Completed Elective Cases in Planned Elective Lists by Week



Further information is available from the office of the Director of Performance which includes:

- tolerances for red, amber and green

Further information on our performance can be found online at:

- Our website [www.bcu.wales.nhs.uk](http://www.bcu.wales.nhs.uk)
- Stats Wales <https://statswales.gov.wales/Catalogue/Health-and-Social-Care>

We also post regular updates on what we are doing to improve healthcare services for patients on social media:

 follow @bcuhb  
 <http://www.facebook.com/bcuhealthboard>



<b>Cyfarfod a dyddiad: Meeting and date:</b>	Quality, Safety and Experience Committee 4 <sup>th</sup> May 2021					
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public					
<b>Teitl yr Adroddiad Report Title:</b>	Board Assurance Framework (BAF) and Corporate Risk Report (CRR)					
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Louise Brereton, Board Secretary Simon Evans-Evans, Interim Director of Governance					
<b>Awdur yr Adroddiad Report Author:</b>	Dawn Sharp, Assistant Director: Deputy Board Secretary Justine Parry, Assistant Director: Information Governance and Risk					
<b>Craffu blaenorol: Prior Scrutiny:</b>	Executive Team meeting on the 21 April 2021					
<b>Atodiadau Appendices:</b>	Appendix 1 – BAF Report Appendix 2 – Overview of all BAF risks and definition of assurance levels Appendix 3a – Corporate Tier 1 Operational Risk Report Appendix 3b – Operational Risk for Escalation					
<b>Argymhelliad / Recommendation:</b>						
That the Committee:-						
(1) review and note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF);						
(2) review and note the progress on the Corporate Tier 1 Operational Risk Report.						
i) approve the completion of CRR20-01 actions so they can be archived and removed from the next report						
ii) approve the reduction of score in CRR10-01 in line with completed actions to support the mitigation of the risk.						
Please tick as appropriate						
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>	<input checked="" type="checkbox"/>	<b>Ar gyfer Trafodaeth For Discussion</b>	<input checked="" type="checkbox"/>	<b>Ar gyfer sicrwydd For Assurance</b>	<input type="checkbox"/>	<b>Er gwybodaeth For Information</b>
<b>Y/N to indicate whether the Equality/SED duty is applicable</b>						
<b>N</b>						
<b>Sefyllfa / Situation:</b>						
The revised Risk Management Strategy and Policy was implemented on the 1 <sup>st</sup> October 2020, and on the 21 <sup>st</sup> January 2021, the Board approved the implementation of the revised Board Assurance Framework (BAF) template reporting arrangements.						
This new design captures the work undertaken by the Board on the identification of its Priority Areas to support the effective management of the agreed Principal Risks that could affect the achievement of its agreed Priorities. This has led to streamlining and re-design of the Corporate Risk Register						



(CRR), which more effectively demonstrates how the Health Board is robustly mitigating and managing high rated risks to the achievement of its operational objectives.

Each BAF risk has since been reviewed and updated.

**Appendix 1** highlights the Board Assurance Framework Risk assigned to this Committee.

**Appendix 2** provides an overview of all BAF risks and also details of the definitions of the assurance levels as requested at the last meeting.

**Appendix 3a** highlights the Corporate Tier 1 Operational Risks with **Appendix 3b** detailing the operational risks for escalation.

### Cefndir / Background:

The design of both the new BAF and CRR emphasises their distinctive roles in underpinning the effective management of both strategic and operational risks respectively, as well as underlining their symbiotic relationship as both mechanisms have been designed to inform and feed-off each other. This includes the evaluation, monitoring and review of progress, accountability and oversight of the Principal Risks and also the high level operational risks which could affect the achievement of the Health Board's agreed Priorities. These are being monitored by regular review with respective leads and oversight by the Risk Management Group and Executive Team.

### Board Assurance Framework

Oversight and co-ordination of the BAF has transferred to the Office of the Board Secretary from the Corporate Risk Management Team, with the risk management system and process continuing to be managed by the Corporate Risk Team. It is worth emphasising that ownership of the BAF rests with the Board with individual Executives being responsible for the management of their respective risks, not the Board Secretary. Engagement with risk leads continues to progress well and work continues to refine and further develop the BAF to ensure it becomes a tool to ensure strategic risks are visible to the Board and Committees.

It is recognised there are a number of risks where the target risk score is above the current risk appetite and discussions with risk leads have explored this concluding that the operating environment and challenges due to the pandemic mean that for some risks there is a need to reconsider risk appetite and subsequently target risk scores. Taking this into account, it has been agreed that a review of the risk appetite will be undertaken by the Board at the workshop arranged for 27<sup>th</sup> April. A realignment/refresh of the risks aligned to the Draft Annual Plan is also underway and will be shared with Board members shortly.

Key progress on the BAF risks assigned to this Committee are detailed below (this information is also reflected within the relevant BAF risk sheet):-

- **BAF20-02 – Safe and Effective Management of Unscheduled Care (formerly titled Emergency Care Review Recommendations)**

Key progress since the last review have been:

- Key controls, gaps and mitigations have been updated to reflect the current position and agreement of annual plan.

- Elements of outstanding actions from BAF risk 20-01 regarding the Winter Plan have now incorporated into this risk.
- The risk title has been amended to '*Safe and Effective Management of Unscheduled Care*' as proposed by the Risk Management Group.
- The current risk score has been reduced from 20 {4x5} to 16 {4x4} to reflect the progress against the USC plans
- Actions have been reviewed in terms of which would have the most material impact on the risk. It is considered that it is the collective impact of the actions that will mitigate the risk.

- **BAF 20-05 – Timely Access to Planned Care (reporting to both Finance & Performance [F&P] Committee and QSE)**

Key progress since the last review have been:

- Risk mitigations and Gaps/Actions have been updated to reflect current developments including extension to some timelines.
- Further actions have been added which include the scoping of Artificial Intelligence approach to validation which requires IT infrastructure and engagement of Informatics to ensure the inclusion of the scheme within the Informatics Business Plan; the introduction of risk stratification for stages 1-3 (outpatients and diagnostics) with work currently ongoing with Welsh Government; Agreement of over 52 week recovery plan for the 2019/20 end of March cohort as first phase; and a review of the Ophthalmology Business Case in light of Welsh Government Strategy re. Cataract Centres.
- Actions have been reviewed in terms of which would have the most material impact on the risk. It is considered that it is the collective impact of the actions that will mitigate the risk.

- **BAF20-08 – Safe and Effective Mental Health Service Delivery**

Key progress since the last review have been:

- Controls, mitigations and actions have been updated.
- Ensuring the effective working of the Together for Mental Health Partnership Board (T4MHPB) will have the most material impact on this risk.

- **BAF20-09 – Mental Health Leadership Model**

Key progress since the last review have been:

- Actions have been reviewed and updated to reflect the current position with target dates amended.
- Actions have been collectively reviewed and it is considered that the stability of the leadership team will have the most material impact on the risk.

- **BAF20-10 – Mental Health Service Delivery During Pandemic Management**

Key progress since the last review have been:

- A number of completed actions have transferred across to now become mitigations and action dates reviewed and updated.
- Actions have been reviewed in terms of which would have the most material impact on the risk - it is considered that it is the collective impact of the actions that will mitigate the risk.

- **BAF20-11 – Infection Prevention and Control**

Key progress since the last review have been:

- Additional actions identified and added including decamp facilities, isolation facilities, IT and information solutions.
- Actions reviewed in terms of which would have the most material impact on the risk - it is considered that the action to build or purchase more isolation facilities would have the most material impact on this risk.

- **BAF20-12 – Listening and Learning**

Key progress since the last review have been:

- Target action dates reviewed and updated, acknowledging the impact of Covid on some action deadline dates.
- An addition action has been added regarding the 'Speak Out Safely' work.
- Actions have been mapped to the three elements of the risk.
- Actions have been reviewed in terms of which would have the most material impact on the risk - it is considered that it is the collective impact of the actions that will mitigate the risk.

- **BAF20-13 – Culture / Staff Engagement**

Key progress since the last review have been:

- New 'Speak Out Safely' process is being implemented with the aim of full implementation of all actions by end of May 2021.
- It is considered that the collective impact of the actions for Raising Concerns will mitigate the risk.

- **BAF20-14 – Security Services**

Key progress since the last review have been:

- The current risk score has been increased to 20 {5x4} from 15 {5x3} reflecting the additional challenges identified as a result of the dispute with the previous provider together with the lack of capacity internally to manage the extent of these challenges consistently and systematically.
- Action timeframes have been reviewed and updated.
- Controls have also been updated to confirm the new security contract arrangements from 1st April 2021.
- It is considered that the following actions will have the most material impact on the risk: Support for the case for investment and change to improve capacity and quality of the security service and management; Implementation of the gap analysis findings;

- **BAF20-15 – Health and Safety**

Key progress since the last review have been:

- Mitigations updated to reflect current position with regard to Annual Plan and also the increase in the number of RIDDOR reports (from 110 2019-20 to 820 in 2020-21).
- Additional action now added reflecting water safety following Legionella Review

- It is considered that the action that will have the most material impact on the risk is the competence and leadership training programme including IOSH Managing Safely and Leading Safely Modules for Senior Leadership.

- **BAF20-16 – Pandemic Exposure**

Key progress since the last review have been:

- Controls and actions updated to include revised governance structure including establishment of the Safe Clean Care Harm Free Steering Group and reference to the purchase of more isolation facilities.
- Actions reviewed in terms of which would have the most material impact on the risk - it is considered that the purchase/building of more isolation facilities will have the most material impact on this risk.

- **BAF20-25 – Impact of COVID-19**

Key progress since the last review have been:

- Controls, mitigations and actions together with timeframes updated to reflect the current position of the pandemic.
- Current risk score revised to 12 {4x3} to reflect reduced impact given the implementation of the vaccination programme (previous score 15 {5x3}).
- It is considered that the collective impact of the actions listed will mitigate the risk.

### **Corporate Risk Register:**

It is important to note that the Health Board's new CRR has been updated following feedback received on the previous version. Changes have been made to the terminology used for example the "Initial Risk Score" has now changed to Inherent and the continued use of the "Action Plan Module" as a key driver to capture and monitor the completion of actions is proving beneficial for all leads as regular reminders are issued once the completion date has expired.

The Corporate Risk Management Team Staff continue to explore engagement, training, capacity building and understanding as drivers for embedding the new CRR and a positive risk-aware culture across the Health Board. Delivery of the RM03 - Risk Management Training Plan for 2021/22 has commenced in April, with dates being advertised on the intranet and in the corporate bulletin. This training includes the management of risk in line with the Risk Management Strategy for managers and also practical training for developing, managing and reporting risks for risk handlers. Following the delivery of the training in April, feedback will be collated and used to influence further training from June 2021 onwards.

In addition to the above, the Corporate Risk Management Team also attend existing meetings and networks in place to deliver the training, for example: Junior Doctors meetings or Consultant's meetings.

In summary, a close look at the CRR in Appendix 3a demonstrates that:

- **CRR20-01 - Asbestos Management and Control**

Key progress since last submission to the Committee: Following on from the Health and Safety Audit in 2019, and the subsequent detailed action plan to address the non-conformances, nine out of the identified eleven actions have been implemented to support in mitigation and management of the risk to reduce the risk score. A scheduled asbestos audit will be also undertaken in September 2021 to further support the management and mitigation of this risk.

The Committee is therefore requested to approve the completion of these actions so they can be archived and removed from the next report. In line with the completion of these actions, the Committee is also requested to approve the reduction in the risk score from twenty to fifteen.

This risk is being actively managed by the Executive Director of Planning and Performance with oversight by the Risk Management Group and the Executive Team.

- **CRR20-02 - Contractor Management and Control**

Key progress since last submission to the Committee: Following on from the Health and Safety Audit in 2019, and the subsequent detailed action plan to address the non-conformances in Contractor Management and Control, three out of the identified twelve actions have been implemented to support in mitigation and management of the risk. Fundamental to addressing this risk, is the procurement of an IT System. Funding has been allocated to enable the purchase of the new software solution which going through suitability assessment and procurement through Shared Services. Adoption of a new BCU-wide contractor management system will enable not only the Estates and Facilities Department but others Corporate Service Departments to demonstrate contractor control compliance.

This risk is being actively managed by the Executive Director of Planning and Performance with oversight by the Risk Management Group and the Executive Team.

- **CRR20-03 – Legionella Management and Control**

Key progress since last submission to the Committee: Following the Corporate Health and Safety Audit in 2019 for Legionella Management a number of areas were assessed as non-compliant. A detailed action plan has been implemented to address and correct the non-conformances raised. The actions and target risk date have been reviewed and where appropriate have been extended to take into account the impact on the Health Board for the management of the second wave of the COVID-19 Pandemic. Whilst one out of the initial ten actions has been implemented, the following have been progressed to strengthen compliance and reporting with regards to Wales Safety Management:

1. Awarding of a BCU-wide Water Safety Management contract for a period of 3 years to ClearWater;
2. Appointed ClearWater to draft a water safety plan for BCU-wide;
3. A re-written water policy is in progress with a completion date of June 2021, this will incorporate all required water safety plans.

This risk is being actively managed by the Executive Director of Planning and Performance with oversight by the Risk Management Group and the Executive Team.

- **CRR20-04 - Non-Compliance of Fire Safety Systems**

Key progress since last submission to the Committee: Following on from the Health and Safety Audit in 2019, and the subsequent detailed action plan to address the non-conformances in

Fire Safety Management, five out of the identified thirteen actions have been implemented to support in mitigation and management of the risk to reduce the risk score. The Health Board is continuing to drive forward a number of fire safety related work-streams. These include joint working with the Health Board's authorised Fire Safety Engineer to undertake additional fire safety audits across all premises that has inpatients above ground floor level. The Health Board has also been successful in securing additional capital investment through the Welsh Government Fire Safety Programme. This new funding will be used to invest in the risks identified in a number of fire safety audits, which will further support the mitigation and management of this risk and reduce the current risk score.

This risk is being actively managed by the Executive Director of Planning and Performance with oversight by the Risk Management Group and the Executive Team.

- **CRR20-05 – Timely access to Care Homes**

Key progress since last submission to the Committee: Nine out of the twenty six identified actions have been completed and implemented to support the mitigation and management of this risk.

This risk is being actively managed by the Executive Director of Primary and Community Care with oversight by the Risk Management Group and the Executive Team.

- **CRR20-08 – Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.**

Key progress since last submission to the Committee: Following a review and scrutiny of this risk at the Risk Management Group, its description, controls and further actions have been strengthened to incorporate the review and implementation of the revised pathway. Lead officers responsible for this risk have also been updated to include the Chief Operating Officer.

This risk is being actively managed by the Executive Director of Nursing and Midwifery with oversight by the Risk Management Group and the Executive Team.

During the Executive Team meeting on the 21<sup>st</sup> April, it was agreed to escalate the following operational risk (as set out in Appendix 3b) onto the Corporate Tier 1 Risk Register:

- i. **Risk Reference – 1925 – Potential harm to patients arising from delays in patient IVT treatment.** This risk has been reviewed and its description and controls have been strengthened. The further actions have been updated to reflect how these will help mitigate or reduce risk. The current score can't be reduced lower than inherent risk score to take cognisance of the controls in place due to the negative impact of Covid-19, hence specific actions have been identified which will help mitigate the negative impact of capacity post-covid-19.

In addition to the above risks, the operational risk outlined below is currently being assessed by the Secondary Care Governance Team for escalation consideration:

- Risk ID2501 – Paediatric Retinopathy of prematurity (ROP) Screening

Below is a heat map representation of the BAF and Corporate current risk scores for this Committee:

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5				CRR20-04	BAF 20-05
	Likely - 4				BAF 20-02 BAF 20-13 CRR20-03	BAF 20-08 BAF 20-11 BAF 20-12 BAF 20-14 BAF 20-15 BAF 20-16  CRR20-02 CRR20-08
	Possible - 3			BAF 20-10	BAF 20-25	BAF 20-09  CRR20-01 CRR20-05
	Unlikely - 2					
	Rare - 1					

## Asesiad / Assessment & Analysis

### Strategy Implications

The implementation of the Board Assurance Framework and the revised Risk Management Strategy and Policy aligns with the Health Board's strategy to embed effective risk management in fostering its culture of safety, learning to prevent recurrence and continuous improvements in patient, quality and enhanced experience.

### Options considered

Not applicable.

### Financial Implications

The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.

Due to the improved and increased reporting frequency arrangements, the management of the BAF is resource intensive and so additional resources may be required.

### Risk Analysis

See the individual risks for details of the related risk implications.

**Legal and Compliance**

There are no legal and compliance issues associated with the delivery of the Board Assurance Framework or the Risk Management Strategy and Policy.

**Impact Assessment**

No specific or separate EqIA has been done for this report, as a full EqIA has been completed in relation to the new Risk Management Strategy and Policy to which the BAF and CRR reports are aligned.

Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.



Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps ( <i>actions to achieve target risk score</i> )	Date
Unscheduled Care Improvement Group in place to oversee the improvement programme of work and monitor performance which provides regular reports to the Finance & Performance.	2	1) Ysbyty Glan Clwyd (YGC) improvement plans in place and approved by Executive Team for ambulance handover and flow including EDQDF. 2) Emergency Department (ED) dashboard established which monitors performance. 3) Established Tactical Control Centres in place. 4) Standardised SITREP / escalation reports submitted 3 x day. 5) Primary Care Urgent Treatment (PCUT) Centre established in East	2	1) Roll out of YGC improvement plan to other sites as appropriate. National support agreed. 2) Identify improvement and project support for delivery of the objectives. 3) In line with Welsh Government (WG) directive, implement Phone First programme that will ensure patients are seen by the right person, in the right place, first time. 4) In line with the agreed standards implement a uniform model for patient access to and from EDs. 5) Fully implement across NWales the following to require maximising impact Same Day Emergency Care (SDEC) - currently in place in YG and YGC but further work required in East. SDEC is part of USC continuous improvement programme. 6) D2R&A (discharge to rehabilitate and assess) - in progress; 7) 111 - on track to implement by June 2021 and PCUT to be established in Centre and West	30 June 2021 30 June 2021 30 June 2021 30 June 2021 30 September 2021 31 December 2021 30 June 2021
Annual Plan in place and agreed by the Board, with monthly monitoring and review through the Unscheduled Care (USC) Improvement Group.	2	Monthly USC Improvement Group meetings Chaired by the Chief Operating Officer.	1	1) USC scoping review to be undertaken to develop strategic blueprint solution for unscheduled care. 2) Implement recommendations of Kendal Bluck Emergency Department workforce review related to unscheduled care.	Complete 30 April 2021
Interim COO / Interim Director of USC overseeing the Annual plan in respect of USC and variance to the plan with regular reporting to the Finance and Performance Committee.	2	Bi-monthly report to Finance & Performance Committee to provide assurance on unscheduled care strategic developments.	2	Establish permanent substantive posts currently covered on an interim basis, providing continuity and sustained leadership for unscheduled care.	30 June 2021

<b>Executive Lead:</b> Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	<b>Board / Committee:</b> Quality, Safety and Experience Committee	<b>Review Date:</b> <b>7 April 2021</b>
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**Linked to Operational Corporate Risks:**



### Strategic Priority 3: Mental Health Services

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps ( <i>actions to achieve target risk score</i> )	Date
Mental Health and Learning Disabilities Divisional Governance Structure is in place and aligned to corporate governance requirements, providing consistent approach across the Division.	1	1) Key divisional roles in governance and safety are in the process of aligning to corporate reporting from the 1.11.20. 2) Formal reporting and financial transfer of budget complete to ensure the alignment of governance and associated roles to BCUHB corporate.	2		
Partnership and assurance structures are in place. These are: Together for Mental Health Partnership Board (T4MHPB), Local Authority Scrutiny meetings, Local Implementation Teams (LIT), North Wales Adult Safeguarding Board is in place and the division is in attendance. All meetings are formerly minuted and reported with membership regularly reviewed according to their Terms of Reference. The East Local Implementation Team has been re-established; work is ongoing to re-establish in the other Areas. There has been a review of the Terms of Reference of the T4MHPB.	1	Partnership working and reporting assures flow of information and raising of any concerns over delivery or equity. North Wales Community Health Council have held a number of formal stakeholder listening events for the division and a report from the CHC has now been received. The Director of Mental Health meets formally with the 6 local authority directors.	1	1) The T4MH Partnership Board is now meeting regularly (last met on 9 April 2021). Interim Deputy Director leading this key partnership agenda.	30 June 2021
The Mental Health Learning Disabilities Divisions Senior Leadership Team in place with regular cycle of business meetings. This is a control for the delivery of safe and effective services. Regular reports are presented to the appropriate governance body.	1	1)The Mental Health Learning Disability Division has an agreed management structure (2019). It provides timely reports to the agreed Committees of the Board and the Executive Team and is held to account by them for delivery of a safe and effective Mental Health and Learning Disability Service. 2) Divisional triumvirate in place (albeit interim cover is currently in place through to September 2021). The division has created 2 additional Deputy Directors in post reporting to the Director of Mental health to fill operating gaps in	2	Work is ongoing to address interim roles in the management structure. There is a "Head of Psychology" role currently vacant in the Senior Leadership Team, action is in place to fill this role.	30 June 2021

Review comments since last report: Controls, mitigations and actions updated. Ensuring the effective working of the T4MHPB will have the most material impact on this risk.

Linked to Operational Corporate Risks:	
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Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps ( <i>actions to achieve target risk score</i> )	Date
New leadership in place with revised governance arrangements supporting Infection Prevention.	2	Business case approved and recruitment commenced to increase IPC team/resource. Risk register monitored and escalated via IPSG and Patient Safety & Quality Group.  Safe, clean care harm free programme commenced.	2	1) Analysis to be undertaken to ensure that there is the right leadership in place across Directorates/Divisions/Teams who understand infection prevention and the appropriate escalation arrangements in place across the Health Board.  2) Finalise recruitment to increase IPC Team resource.  3) To develop the leadership to influence culture and behaviours to ensure that infection prevention becomes habit. This is an integral part of the safe, clean care harm free programme.  4) IT solution and information leadership required to ensure that the right data is captured which can then be transformed into intelligence, so that people delivering care can see that they are delivering safe practice (real time system).	31 December 2021  30 September 2021  31 December 2021  31 December 2021
Infection Prevention Sub Group in place providing regular oversight and gaining assurance that the key controls are in place and effective, reporting into Quality, Safety and Experience Committee.	2	Monitoring of performance and risk in place by Public Health Wales and Welsh Government.	3	1) Identify decamp facilities on all clinical sites to ensure an effective deep cleaning programme (Hydrogen Peroxide Vapour {HPV})  2) To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours.	31 October 2021
Major Outbreak policy (IPO5) currently in place for managing Covid 19 infections.	2	Work, policy and risk register review programmes in place. Microbiology and Antimicrobial stewardship activity overseen by Infection Prevention Sub Group (IPSG), Audit Committee/ Patient Safety & Quality Group and Quality and Safety Executive.	2	Strengthening of effective reporting arrangements through outbreak control groups and IPSG.	30 September 2021

<b>Executive Lead:</b> Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	<b>Board / Committee:</b> Quality, Safety and Experience Committee	<b>Review Date:</b> <b>1 April 2021</b>
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**Linked to Operational Corporate Risks:**

## Strategic Priority 4: Safe and Secure Environment

Review comments since last report: Target action dates reviewed and updated, acknowledging impact of Covid on some action deadline dates. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that it is the collective impact of the actions that will mitigate the risk. An addition action has been added regarding the Speak our Safely work. Actions have been mapped to the three elements of the risk.

### Linked to Operational Corporate Risks:



Board Assurance Framework 2020/21									
Strategic Priority 4: Safe and Secure Environment									
Risk Reference: BAF20-13		Risk Rating		Impact	Likelihood	Score	Appetite		
Culture - Staff Engagement									
<p>There is a risk that the Health Board loses the engagement and empowerment of its workforce as a result of staff not feeling that it is safe and/or worthwhile highlighting concerns due to:</p> <p>Lack of clear mechanisms for raising concerns at any and every level, lack of a clear, effective and transparent mechanism for listening, reviewing, addressing, sharing learning and feedback, lack of trust and confidence regarding the reception of and impact of raising concerns, lack of support and guidance for all parties involved. This could lead to an impact on the organisation being able to learn from experience or improve services, which could result in poor staff morale, leading to poor outcomes impacting on the delivery of safe and sustainable services and the reputation of the Health Board.</p>				Inherent Risk	4	5	20	Low 1 - 6	
				Current Risk	4	4	16		
				Target Risk	4	3	12		
Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)			Date		
Key Policies: 1.Raising Concerns Policy 2.Safehaven Guidance	2	Revised new Speak Out Safely process agreed by Remuneration and Terms of Service Committee 1st February 2021. Implementation Plan in place, key elements being: 1. External platform commissioned - Work in Confidence - to replace Safe Haven to enable staff to engage in, dependent on preference, anonymous and/or two way dialogue with Speak Out Safely Guardian and/or members of wider Multi-disciplinary Team. 2. Job outline for first Speak Out Safely Guardian in draft, who will report directly to CEO, with an independent board member also being identified to support and scrutinise Guardian role and new Multi-Disciplinary Team being established which will review concerns raised, agree actions required; and monitor themes to identify learning; 3. Role of Speak Out Safely Champions being refreshed and network of champions being created 4. Communications and promotion strategy under development with support of corporate communications; 5. WP4a policy to be revised to reflect the transition to the new process	1	1. Launch of Work in Confidence platform by early May 2021; 2. Through expressions of interest, appoint first Speak Out Safely Guardian by early May; 3. First meeting of MDT to take place by mid May; 4. Initial meeting with Speak Out Safely Champions by end of April 2021. 5 Commence communications and promotions strategy during April in advance of 'go live' for Work in Confidence and appointment of Speak Out Safely Guardian. 6. WP4a policy revised and agreed by end of May 2021			31st May 2021		
3. Dignity At Work Policy 4. Grievance Policy	2	Assessment of cases upon submission to determine most appropriate process undertaken.  Case management review takes place monthly.  Thematic review in place at operational level.	1	1. Dignity at Work Policy under review at All Wales level. 2. Triangulation of themes to be included within the reporting outlined in Raising concerns review. 3. Simplified Guidance to be developed for managers and staff to follow to promote early resolution. 4. Current training to be reviewed to align to revised approach.			30 September 2021		
5.Performance & Development Review Policy	2	Monthly analysis and reporting at operational level undertaken (as well as strategic level) to enable managers to identify areas with low compliance with PADR.  Staff Engagement, Organisational Development and HR Teams work with challenged areas to support and improve in terms of engagement/feedback/recognition/development.	2	1. Identify improvements to the process and documentation to support specific areas/teams. 2. Develop a programme for "Dip testing" of quality of PADRS against key metrics/feedback. 3. Utilise the survey function of the system implemented for Speak out safely to support identification of examples of outstanding/good and requires improvement. 4. Build "role contribution" into Strategic OD programme specification. 5. Review feedback from NHS Staff Survey and update divisional improvement plans.			30 September 2021		
Review comments since last report: New Speak Out Safely process being implemented with aim of full implementation of all actions by end of May 2021. It is considered that the collective impact of the actions for Raising Concerns will mitigate the risk.									
Executive Lead: Sue Green, Executive Director of Workforce and Organisational Development			Board / Committee: Quality, Safety and Experience Committee				Review Date: 15th April 2021		
Linked to Operational Corporate Risks:									





## Strategic Priority 4: Safe and Secure Environment

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps ( <i>actions to achieve target risk score</i> )	Date
Health and Safety Leadership and Management Training Programme in place across the Health Board, with regular monitoring reported to Strategic H&S group.	1	Competence in training in service areas has been reviewed. Plan in place through business case to establish robust Safety Competence and leadership training programme. There is a three year strategy that requires implementing to support the Strategic Objectives of BCUHB.	2	1)The gap analysis of 31 pieces of legislation,117 site specific inspections including Acute, Mental Health Community Services GP and Wrexham HMP. Identified significant areas of none compliance. The OHS team continues to have significant support from our trade union partners. Further evaluation of H&S systems has been led by Internal Audit. A clear plan and framework for action to firstly identify hazards and place suitable controls in place has been developed. Covid support has significantly effected the delivery of the action plan. 2) IOSH Managing Safely and Leading Safely Modules for Senior Leadership to be implemented.	30 September 2021  31 October 2021
Policies and Sub groups have been established including Asbestos, Water Safety, Fire Electrical Safety etc. to monitor and report into the Strategic Occupational Health & Safety Group and escalate via Quarterly Reports to QSE.	1	Clearly identified objectives for the Annual plan to achieve and transfer of risk ownership for a number of high level risks to E/F as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire.	1	1) Clearly identified issues escalated to Board via business case to be reviewed. Gaps in Fire safety for a number of premises including YG working with North Wales Fire and Rescue service on action plans. Close working relationship with HSE to ensure key risks and information required is provided in a timely manner. HSE are scrutinising work activity in many areas, likely to Audit BCUHB for Asbestos and Violence at work shortly. 2)Actions arising from the Legonella review to be implemented.	30 September 2021  31 October 2021
Lessons Learnt analysis from COVID reported to Executive Team, Through Covid Group and with action to progressed to appropriate Executives. Clear strategy from Board to deal with PPE and suitable control measures to minimise risk of transmission of Covid through risk assessment, safe distancing advice, FAQ's, ICT Audits, guidance and standard operating procedures.	2	RIDDOR reporting in place with robust timeline and tracking through outbreak groups of Datix 72 hour reviews a total of 820 RIDDOR investigations undertaken since April 2020. PPE steering group has weekly meetings and a 'triple A' assurance report is provided to QSG and key issues escalated via QSE. Over 200 site safety visits undertaken by the H&S Team to review Covid safe environments. Action cards in place to ensure movement of staff effectively managed during outbreak.	3	HSE have identified gaps in COSHH Regulations specifically fit testing which requires fit2fit training programme to be in place. Improvement Notice from HSE against BCUHB provided on 24th October was lifted at the beginning of April. There has been significant investment with fit testing equipment with further plans in place to continue fit testing on new masks. There will be a requirement to release fit testers and staff to comply with legal compliance required within all service areas. Full time fit testing staff are required as the current arrangement is predicated on temporary staffing.	30 September 2021
Executive Team understand the range and types of risks identified through Annual Report and Gap analysis. Gaps in safety including areas of inefficiency to be addressed. Internal Audit have reviewed structure of meetings and Governance procedures	1	Strategic OHS Group established to monitor performance and workshop with OD support has looked at leadership styles and developing a positive culture with partners from finance, procurement, Estates and Facilities and Occupational Health	2	Robust action plan with clear objectives for Team difficult to deal with all elements of legislative compliance with limited capacity. Action: Recommending specialist support to review key areas of risk and attendance at operational groups to further understand significant risks.	30 September 2021

Review comments since last report: Mitigations updated to reflect current position with regard to Annual Plan and also the number of RIDDOR reports. Additional action included regarding water safety following Legionella Review. It is considered that the action that will have the most material impact on the risk is the Competence and leadership training programme including IOSH Managing Safely and Leading Safely Modules for Senior Leadership.

<b>Executive Lead:</b> Sue Green, Executive Director of Workforce and Organisational Development	<b>Board / Committee:</b> Quality, Safety and Experience Committee	<b>Review Date:</b> 13 April 2021
<b>Linked to Operational Corporate Risks:</b> <div> CRR20-01 - Asbestos Management and Control CRR20-02 - Contractor Management and Control CRR20-03 - Legionella Management and Control CRR20-04 - Non-Compliance of Fire Safety Systems </div>		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps <i>(actions to achieve target risk score)</i>	Date
PPE monitoring and management in place with regular reporting to the Patient Safety and Quality Group and reporting through to Quality, Safety and Experience Committee.	1	PPE steering group (PPESG) and reporting into Infection Prevention Sub Group, Patient Safety & Quality Group with governance structure in place. In addition the formation of the Safe Clean Care Harm Free Group which now reports to Quality,Safety and Experience Committee.	2	Continuous supply is not secure, training availability limited due to staffing resource in PPE and IPC teams. BCUHB to approve second admission screen.	30 September 2021
Fit testing in place to prevent avoidable infection. This is monitored via IPSP and OH&SG.	1	Fit testing programme, Accreditation training and business case in place to increase assurance monitored by PPESG.	2	Establish a routine programme to ensure continuous review of dynamic plan for fit testing with plan being kept under review by IPSP	30 April 2021
Review of all buildings has taken place against new regulations in relation to what the clinical environment should look like with regard to infection prevention, with a schedule of improvements identified.	1	Ventilation and Environmental groups reporting into Infection Prevention Sub Group and Patient Safety & Quality Group with governance structure in place. Implementation of segregation and screening to clinical areas.	1	1) Review and risk assess the improvement plans in order to address the environmental considerations necessary to meet new guidance in relation to the built environment. Some buildings are a risk due to infrastructure (dialysis and community hospitals). Improvement plans in place via Planning and Estates. 2) To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours.	30 September 2021  31 December 2021

<b>Executive Lead:</b> Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	<b>Board / Committee:</b> Quality, Safety and Experience Committee	<b>Review Date:</b> <b>1 April 2021</b>
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**Linked to Operational Corporate Risks:**





BAF Ref.	Title	Risk	Committee	Executive	Lead
20-01	Surge/ Winter Plan	There is a risk that the Health Board may not be able to deliver the winter plan due to the appropriate availability of capacity and capability of its resources and external collaboration. This could negatively impact on the quality of planned patient care services and the reputation of the organisation.	F&P - proposal to re-assign to SPPH	Mark Wilkinson	Meinir Williams
20-02	Safe and Effective Management of Unscheduled Care (formerly titled Emergency Care Review Recommendations)	There is a risk that the Health Board may not be able to deliver safe and effective care due to being unable to commit support processes. This could negatively impact on the quality of patient care provided.	QSE	Gill Harris	Meinir Williams
20-03	Sustainable Key Health Services	There is a risk that the Health Board may not be able to deliver sustainable key population health services to the wider population of North Wales due to diminishing capacity to meet an ever-growing demand.	SPPH	Teresa Owen	Gwyneth Page
20-04	Primary Care Sustainable Health Services	There is a risk that the Health Board will be unable to ensure timely access to Primary Care (GMS) Services for the population due to growing demand and complexity, an ageing workforce and a shift of more services out of hospital. As a gateway to health care, this could result in a deterioration in the population health, impacting on other health & care services and the wellbeing of the primary care workforce.	SPPH	Chris Stockport	Clare Darlington
20-05	Timely Access to Planned Care	There is a risk that the Health Board may be unable to deliver timely access to Planned Care due a mismatch between demand and capacity and Covid-19, which could result in a significant backlog and potential clinical deterioration in some patient conditions.	F&P and QSE	Mark Wilkinson	Andrew Kent

BAF Ref.	Title	Risk	Committee	Executive	Lead
20-07	Effective Stakeholder Relationships	There is a risk that our relationships (internal and external) are ineffective. This could be caused by a lack of engagement, poorer communication, a lack of a co-productive approach, lack of direction, shared purpose and culture or insufficient service and organisational development. This could lead to a lack of trust, poor morale, high staff turnover, reduced stakeholder credibility plus reduced staff and public confidence, and an impact on services.	SPPH	Teresa Owen	Amanda Lonsdale
20-08	Safe and Effective Mental Health Delivery	There is a risk to the safe and effective delivery of Mental Health and Learning Disabilities (MHLD) services. This could be due to unwarranted variation and inefficiencies. This could lead to poorer and inconsistent outcomes, poorer use of resources, failure to learn from events or inequity of access.	QSE	Teresa Owen	Mike Smith
20-09	Mental Health Leadership Model	There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.	QSE	Teresa Owen	Keeley Twigg
20-10	Mental Health Service Delivery During Pandemic Management	There is a risk to the safe and effective delivery of MHLD services. This could be due to the consequences of the COVID-19 pandemic. This could lead to changing type and level of demand across the region, a lack of appropriate staff and resources, poorer outcomes for our population.	QSE	Teresa Owen	Carole Evanson
20-11	Infection Prevention and Control	There is a risk that Health Board may not be able to deliver appropriate care to patients and they may suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase	QSE	Gill Harris	Sally Batley

		treatment costs, reputational damage and loss of public confidence.			
BAF Ref.	Title	Risk	Committee	Executive	Lead
20-12	Listening and Learning	There is a risk that adverse events occur, or re-occur, in the organisation due to: 1) Lack of a clear and easy mechanism for patients or staff to raise incidents or complaints, 2) lack of a clear, effective and transparent mechanism for reviewing, addressing, sharing learning and feedback from reviews/investigations, 3) lack of trust and confidence in the systems and process. These adverse events could result in avoidable harm to patients or staff, disruption to clinical and support services, avoidable costs and loss of public and stakeholder confidence.	QSE	Gill Harris	Matt Joyes
20-13	Culture – Staff Engagement	There is a risk that the Health Board loses the engagement and empowerment of its workforce as a result of staff not feeling that it is safe and/or worthwhile highlighting concerns due to: Lack of clear mechanisms for raising concerns at any and every level, lack of a clear, effective and transparent mechanism for listening, reviewing, addressing, sharing learning and feedback, lack of trust and confidence regarding the reception of and impact of raising concerns, lack of support and guidance for all parties involved. This could lead to an impact on the organisation being able to learn from experience or improve services, which could result in poor staff morale, leading to poor outcomes impacting on the delivery of safe and sustainable services and the reputation of the Health Board.	QSE	Sue Green	Ellen Greer
20-14	Security Services	There is a risk that the Health Board does not provide effective security services across the organisation. This is due to lack of formal arrangements in place to protect premises and people in relation to CCTV, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed. This	QSE	Sue Green	Peter Bohan

		could lead to a breach in the Health Board's statutory security duties.			
BAF Ref.	Title	Risk	Committee	Executive	Lead
20-15	Health and Safety	There is a risk that the Health Board fails in its statutory duty to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation that could result in avoidable harm or loss.	QSE	Sue Green	Peter Bohan
20-16	Pandemic Exposure	There is risk that patients, staff or visitors are exposed to COVID-19 due to inadequate/inappropriate resources, lack of compliance with prevention/protection measures across all settings, lack of understanding, skills, ownership of responsibilities, lack of systems and/or capacity and/or capability to identify, analyse, adapt, address immediate themes arising from intelligence both internal and external in a dynamic way. This could impact or effect avoidable harm caused to our patients, staff, visitors, increase in demand/length of stay/risk to other patients, reduction in availability of staff to support the delivery of safe care and services. This could led to prosecution for breach of statutory/legal duty and reputational damage to trust and confidence.	QSE	Gill Harris	Sally Batley
20-17	Value Based Improvement Programme	There is a risk that the Health Board does not understand or use its resources effectively and efficiently due to a lack of implementing an appropriately resourced value based improvement programme. This could impact on the quality of outcomes for the services it delivers.	F&P	Sue Hill	Geoff Lang
20-18	Digital Estate and Assets	There is a risk that Informatics cannot implement digital solutions due to available resource not keeping step with an organisational wish to become more digitally focused. This could impact on the safety of our patients, service efficiency and the reputation of the Health Board, the ability to recruit and retain staff or impact on	DIG	Chris Stockport	Dylan Williams



		compliance with legislation resulting in significant financial penalties.			
BAF Ref.	Title	Risk	Committee	Executive	Lead
20-20	Estates and Assets Development	There is a risk that the Health Board does not systematically review and capitalise on the opportunity to develop its estates and assets due to changes in working practices (for example agile working) which could impact on recruitment, financial balance and the reputation of the Health Board.	SPPH	Mark Wilkinson	Rod Taylor
20-21	Workforce Optimisation	There is a risk that the Health Board cannot attract or retain sufficient staff (core and flexible) to resource delivery of the strategic priorities due to a lack of integrated workforce planning, safe deployment systems and insufficient support for recruitment and on boarding. This could impact on the Board's ability to deliver safe and sustainable services.	SPPH agreed to transfer to F&P	Sue Green	Nick Graham
20-25	Impact of COVID-19	There is a risk that the ongoing Covid-19 pandemic will lead to the HB being overwhelmed and unable to respond to Covid healthcare needs and/or carry out its core functions due to the spread and impact of Covid-19 in North Wales. This could lead to reduced staff numbers available for work, increased demand on services (including acute, community, mental health and primary care), and suspension of planned services. This could negatively affect patient safety and quality of care, patient outcomes; delivery of the mass vaccination programme and Test, Trace Protect (TTP); and the Health Board's ability to deliver its plans and corporate priorities.	QSE	Chris Stockport	Sally Baxter
20-26	Development of Annual Operational Plan 2021-22	There is a risk the Health Board fails to deliver a plan to Welsh Government and remains in breach of its statutory duties whether due to inability to deliver financial balance or to present a plan that delivers key performance targets. This impacts on reputation, and reduces freedom to act.	SPPH	Mark Wilkinson	John Darlington

20-27	Delivery of a Planned Annual Budget	There is a risk the Health Board spends in excess of its planned annual budget. Any financial deterioration against the financial plan may result in the Health Board breaching its statutory duties. This could affect the provision of healthcare across North Wales, potentially leading to Welsh Government intervention and reputational damage, impacting on the Health Board's ability to remain sustainable.	F&P	Sue Hill	Rob Nolan
<b>BAF Ref.</b>	<b>Title</b>	<b>Risk</b>	<b>Committee</b>	<b>Executive</b>	<b>Lead</b>
20-28	Estates and Assets	There is a risk that the Health Board fails to provide a safe and compliant built environment, equipment and digital landscape due to limitations in capital funding. This could impact on the Health Board's ability to implement safe and sustainable services through an appropriate refresh programme, could result in avoidable harm to patient, staff, public, reputational damage and litigation.	F&P	Mark Wilkinson	Neil Bradshaw

<b>KEY</b>	DIG	Digital and Information Governance Committee
	F&P	Finance and Performance Committee
	QSE	Quality, Safety and Experience Committee
	SPPH	Strategy, Partnerships and Population Health Committee

### Key Field Guidance

<b>BAF Template Item</b>		<i>Please refer to the Risk Management Strategy and Policy for further detailed explanations</i>
Risk Reference		Board Assurance Framework reference number, allocated by the Board Secretary
Risk Description		An uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's Priority. There are 3 main components to include when articulating the risk description (cause, event and effect):
		- There is a risk of / if ....
		- This may be caused by ....

		- Which could lead to an impact / effect on .....
Risk Ratings	Inherent	Without taking into consideration any controls which may be in place to manage this risk, what is the likelihood that this risk will be realised, and if it did, what would be the consequence
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place.
Risk Impact		The consequence (or how bad) if the risk were to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high)
Risk Likelihood		The probability (frequency or how often) would this happen if the risk were to be realised. In line with the NPSA Grading Matrix a likelihood of 1 is this will probably never happen / recur, with a 5 being that it will undoubtedly happen, recur, possibly frequently
Score		Impact x Likelihood of the risk happening
Appetite	<i>Definition</i>	Is defined as the amount and type of risk the Health Board is willing to take on, pursue or retain in order to achieve its priorities.
	Low	Cautious with a preference for safe delivery options (Score 1 to 6)
	Moderate	Prepared to take on, pursue or retain some risks as a result of the Health Board taking opportunities to improve quality and safety of services (Score 8 to 10)
	High	Open or willing to take on, pursue or retain risks associated with innovation, research and development consistent with the Health Board's Priorities (Score 12-15)
Control	<i>Definition</i>	<p>A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise and ensure that care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - <a href="http://www.wales.nhs.uk/governance-emanual/risk-management">http://www.wales.nhs.uk/governance-emanual/risk-management</a>]</p> <p>A measure that maintains and/or modifies risk (ISO 31000:2018(en))</p>

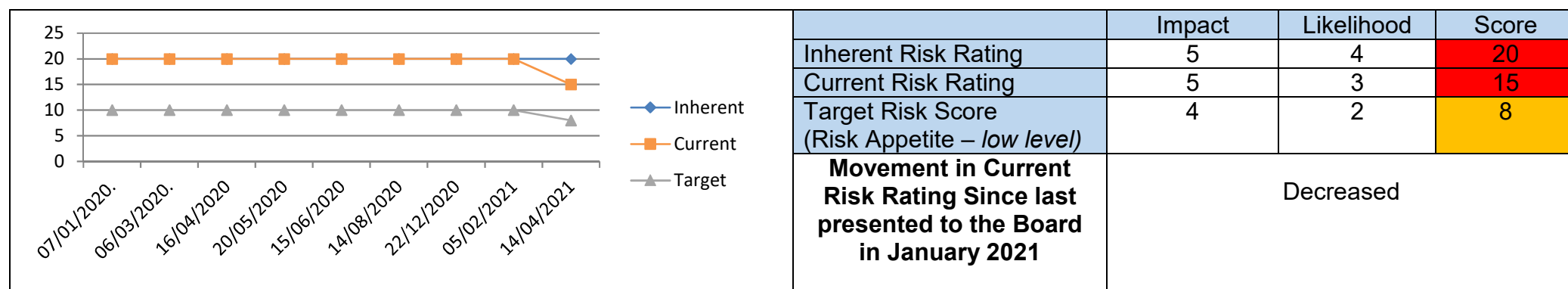
	Examples include, but are not limited to:	<ul style="list-style-type: none"> <li>- People, for example, a person who may have a specific role in delivery of an objective</li> <li>- Strategy, policies, procedures, SOP, checklist in place and being implemented which ensures the delivery of an objective</li> <li>- Training in place, monitored and assurance reported</li> <li>- Compliance audits</li> <li>- Business Continuity plans in place, up to date, tested and effectively monitored</li> <li>- Contract Management in place, up to date and regularly monitored</li> </ul>
Mitigation	<i>Definition</i>	To reduce the extent of risk exposure, and the adverse effects of risk
	Examples include, but are not limited to:	<ul style="list-style-type: none"> <li>- Service or Pathway Redesign</li> <li>- Business Case Development</li> <li>- Staff Training</li> <li>- Risk Assessment</li> <li>- Evidential data sets</li> </ul>
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the data is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified the data, for example quality, finance and H/R assurance
	3	The third level of assurance comes from assurance provided from outside the Health Board, for example WG, HIW, HSE etc.

## Appendix 3a – Corporate Tier 1 Operational Risk Report

CRR20-01	<b>Director Lead:</b> Executive Director of Planning and Performance	<b>Date Opened:</b> 07 January 2020
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee	<b>Date Last Reviewed:</b> 14 April 2021
	<b>Risk:</b> Asbestos Management and Control	<b>Date of Committee Review:</b> 02 March 2021
		<b>Target Risk Date:</b> 31 March 2022

There is a significant risk that BCUHB is non-compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys.

This may lead to the risk of contractors, staff and others being exposed to asbestos, and may result in death from mesothelioma or long term ill health conditions, claims, HSE enforcement action including fines, prosecution and reputation damage to BCUHB.



Controls in place	Assurances
<ol style="list-style-type: none"> <li>1. Asbestos Policy in place (refer to further action 12242).</li> <li>2. A number of surveys undertaken (refer to further action 12241).</li> <li>3. Asbestos management plan in place.</li> <li>4. Asbestos register available (refer to further action 12250).</li> <li>5. Targeted surveys where capital work is planned or decommissioning work undertaken.</li> <li>6. Training for operatives in Estates.</li> <li>7. Air monitoring undertaken in premises where there is limited clarity on asbestos condition (refer to further action 15032).</li> </ol>	<ol style="list-style-type: none"> <li>1. Health and Safety Leads Group.</li> <li>2. Strategic Occupational Health and Safety Group.</li> <li>3. Quality, Safety and Experience Committee.</li> </ol>

Links to Strategic Priorities	Principal Risks
Effective use of our resources	BAF20-15 BAF20-20

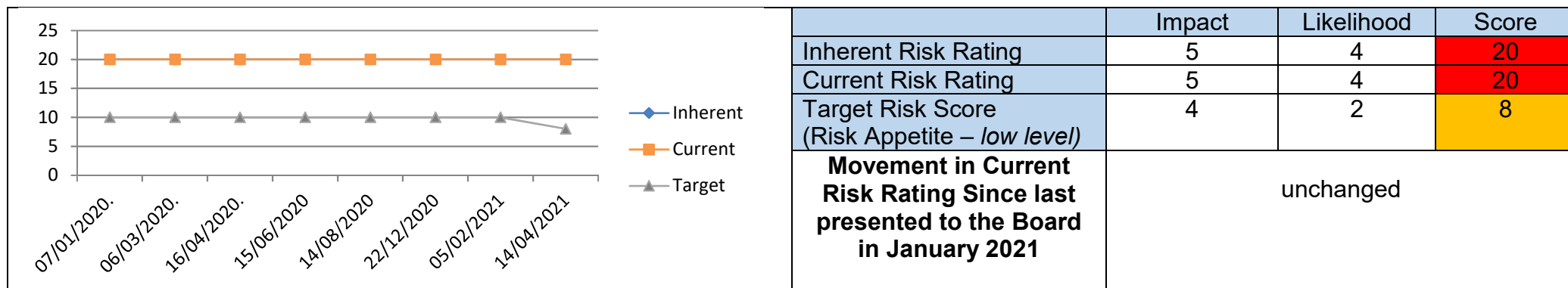
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12241	Undertaking a re-survey of 10-15 premises to determine if the original Asbestos surveys are valid. This is problematic as finances are not available for this work, increasing the risk of exposure to staff and contractors.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	<p>Action Closed 14/04/2021</p> <p>Re-survey of existing asbestos surveys, sample 10 – complete and assurance provided that surveys are robust.</p> <p>Resampling will be included with the updated management plan as an ongoing compliance work stream.</p> <p>Completion of this action was reported to the asbestos management group in Jan 2021.</p>	
	12242	Update and review the Asbestos Policy and Management Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	<p>Action Closed 14/04/2021</p> <p>Action Partially completed - Updated Policy and Management Plan included on the agenda SOH&amp;SG (02-02-2021).</p> <p>Policy partially implemented due to lack of complete asbestos registers on all sites.</p>	
	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	<p>This action will help us to identify the areas of asbestos and thus better mitigate and manage any potential impact by enabling to a web supported system to access records remotely.</p>	

	12244	Ensure priority assessments are undertaken and highest risk escalated.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/2021  Priority assessments and risk reviews – Actions complete and removal / management plan in place.	
	12245	Evaluate how contractors are provided with information and instruction on asbestos within their work environment. Ensure work is monitored.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/2021  Contractor management and control – actions complete with updated permit to work system and contractor control framework.	
	12246	Ensure all asbestos surveys are available at all sites and there is a lead allocated for premises.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 14/04/2021  Asbestos surveys – all site have access to site-specific registers (hard copy). Following the roll out of the asbestos management modal within MICAD, all sites will have access to digital register.	
	12247	Annual asbestos surveys to be tracked and monitor for actions providing positive assurance of actions taken to mitigate risks.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/2021  Annual reinspections – Asbestos Management Group providing oversight and governance with escalation to SOH&SG. Appointed Independent Asbestos Consultants.	
	12248	Update intranet pages and raise awareness with staff who may be affected by asbestos.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Creating staff awareness of the presence of asbestos thus reducing may potential impact.	
	12249	QR Code identification to be provided on all areas of work with identified asbestos signage in non public areas.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 14/04/2021  Action should be closed as not required as there is no legal requirement none one on grounds of best practice.	

	12250	Lack of completed asbestos registers on all sites picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/2021  Corporate Health and Gap analysis – Action plan updated and progress against actions recorded and included within escalation report to SOH&SG.	
	15032	Air Monitoring in all premises where there is limited clarity on asbestos condition.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 14/04/2021  Improve safety and ongoing compliance with the Regulations.	



CRR20-02	<b>Director Lead:</b> Executive Director of Planning and Performance	<b>Date Opened:</b> 07 January 2020
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee	<b>Date Last Reviewed:</b> 14 April 2021
	<b>Risk:</b> Contractor Management and Control	<b>Date of Committee Review:</b> 02 March 2021
		<b>Target Risk Date:</b> 30 September 2022
There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites. This may lead to exposure to substances hazardous to health, non compliance with permit to work systems and result in injury, death, loss including prosecution, fines and reputation damage.		



Controls in place	Assurances
<ol style="list-style-type: none"> <li>Control of contractors procedure in place (refer to further action 12260).</li> <li>Induction process being delivered to new contractors.</li> <li>Permit to work paper systems in place across the Health Board.</li> <li>Pre-contract meetings.</li> <li>Externally appointed CDMC Coordinator (Construction, Design and Management Regulations) in place.</li> <li>Procurement through NHS Shared Services Procurement market test and ensure contractor compliance obligation.</li> </ol>	<ol style="list-style-type: none"> <li>Health and Safety Leads Group.</li> <li>Strategic Occupational Health and Safety Group.</li> <li>Quality, Safety and Experience Committee.</li> </ol>

Links to Strategic Priorities	Principal Risks
Safe, secure & healthy environment for our people	BAF20-15

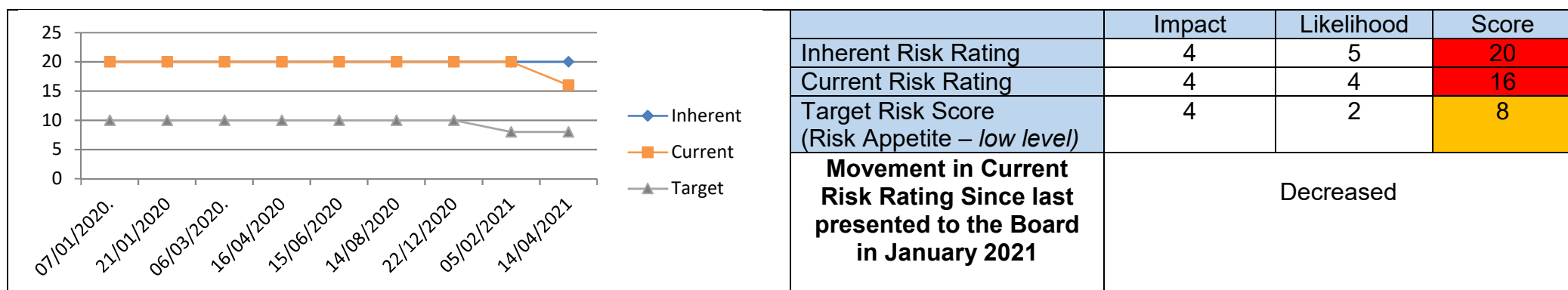
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12251	Identify current guidance documents and ensure they are fit for purpose.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	Action Closed - 31/03/2021 The Control of Contractors Guidance Document is currently being reviewed and updated.	
	12252	Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	
	12253	Draft and implement a Control of Contractors Policy that all adhere to including IT and other services who work on BCUHB premises.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	Action Closed - 31/03/2021 The Control of Contractors Policy Document is currently being drafted.	
	12254	Identify current tender process & evaluation of contractors, particularly for smaller contracts consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum H&S are implemented and externally checked prior to coming top site.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance for contractor's appointment criteria. The process and system will be a Health Board wide management system.	

	12255	Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc. Is the current system fit for purpose and robust?	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.	
	12256	Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE data base.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.	
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	
	12258	Identify responsible person to review RA's and signs off Method Statements (RAMS), skills, knowledge and understanding to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities	

					e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	
	12259	Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A Permit to Work system will be adopted as part of implementation of SHE software.	
	12260	Lack of consistency and standardisation in implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	
	12552	Induction process to be completed by all contractors who have not yet already undertaken.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for addition staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	

	12553	Evaluation of standing orders and assessment under Construction Design and Management Regulations.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	Action Closed - 31/03/2021  The Control of Contractors Guidance Document is currently being reviewed and updated.	
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CRR20-03	<b>Director Lead:</b> Executive Director of Planning and Performance	<b>Date Opened:</b> 07 January 2020
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee	<b>Date Last Reviewed:</b> 14 April 2021
	<b>Risk:</b> Legionella Management and Control	<b>Date of Committee Review:</b> 02 March 2021
		<b>Target Risk Date:</b> 30 September 2022
There is a significant risk that BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines). This is caused by a lack of formal processes and systems, to minimise the risk to staff, patients, visitors and General Public, from water-borne pathogens (such as Pseudomonas). This may ultimately lead to death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.		



Controls in place	Assurances
<ol style="list-style-type: none"> <li>1. Legionella and Water Safety Policy in place (refer to further action 12270).</li> <li>2. Risk assessment undertaken by clear water.</li> <li>3. High risk engineering work completed in line with clearwater risk assessment.</li> <li>4. Bi-Annual risk assessment undertaken by clear water.</li> <li>5. Water samples taken and evaluated for legionella and pseudomonis.</li> <li>6. Authorising Engineer water safety in place who provides annual report.</li> <li>7. Annual Review of the H&amp;S Self Assessments undertaken by the Corporate H&amp;S Team.</li> <li>8. Water safety Group has been established to better provide monitoring, oversight and escalation.</li> <li>9. Internal audit of compliance checks for water safety management regularly undertaken.</li> </ol>	<ol style="list-style-type: none"> <li>1. Health and Safety Leads Group.</li> <li>2. Strategic Occupational Health and Safety Group.</li> <li>3. Quality, Safety and Patient Experience Committee.</li> </ol>

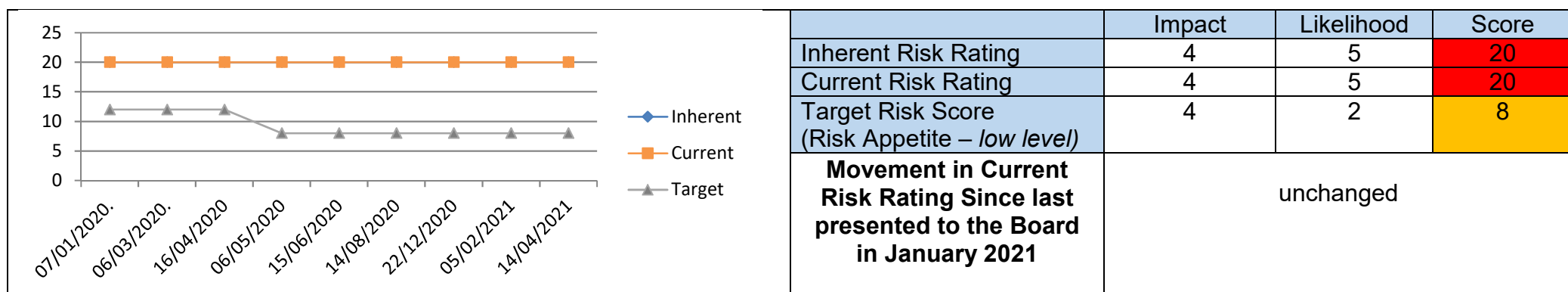
Links to Strategic Priorities	Principal Risks
<p>Effective use of our resources</p> <p>Safe, secure &amp; healthy environment for our people</p>	<p>BAF20-15</p> <p>BAF20-20</p>

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12262	Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	MiCAD (IT) system being rolled out on a phased basis and work has commenced on polylining site drawings (digital site drawings) for migration to MiCAD. Schematic drawings for all sites for water safety being reviewed as part of the new Water Safety Maintenance Contract, which has been approved by the Health Board in January 2021.	
	12263	Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	All water outlets within managed departments have outlets run as part of the cleaning schedule undertaken by domestic services. Deadlegs are removed on identification and assessment of risk.	
	12264	Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A policy for the Management of Safe Water Systems in place to ensure water safety compliance. A programme of flushing of little use outlets in place for un-occupied areas and recorded by Operational Estates for each site.	
	12265	Water quality testing results and flushing to be logged on single system and shared with or accessible by departments/services - potential for dashboard/logging system (Public Health Wales).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Pseudomonas and Legionella sample testing carried out within augmented care areas, exception reports are presented at the Water Safety Group in an excel format. All water testing across BCUHB is undertaken by Operational Estates through Public Health Wales.	

	12266	Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Escalation and notification process is contained within Policy for the Management of Safe Water Systems (Appendix B).	
	12267	Awareness and training programme in place to ensure all staff aware. Departmental Induction Checklist.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A training and development structure for Operational Estates is being reviewed as part of new Water Safety Contract, which has just been approved by the Health Board.	
	12268	BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A policy for water safety management is currently in place – A consultant has been appointed to review current procedural documents for each area with the objective to develop one policy document.	
	12269	Water Safety Group provides assurance that the Policy is being effectively implemented across all sites, this requires appropriate clinical and microbiology support to be effective	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Water Safety Group provides assurance that the Policy is being effectively implemented across all sites; this requires appropriate clinical and microbiology support to be effective. The Water Safety Groups reports issues of significance and assurance to the Infection Prevention Sub-Group (IPSG) and Strategic Occupational Health and Safety Group (SOH&SG).	
	12270	Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Independent Consultant appointed to review the current procedural documents for each area with the objective to develop one policy document.	



CRR20-04	<b>Director Lead:</b> Executive Director of Planning and Performance	<b>Date Opened:</b> 07 January 2020
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee	<b>Date Last Reviewed:</b> 14 April 2021
	<b>Risk:</b> Non-Compliance of Fire Safety Systems	<b>Date of Committee Review:</b> 02 March 2021
		<b>Target Risk Date:</b> 30 September 2022
There is a risk that the Health Board is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of incomplete maintenance risks and lack of relevant operational Risks Assessments. This may lead to a major Fire, breach in Legislation and ultimately prosecution against BCUHB.		



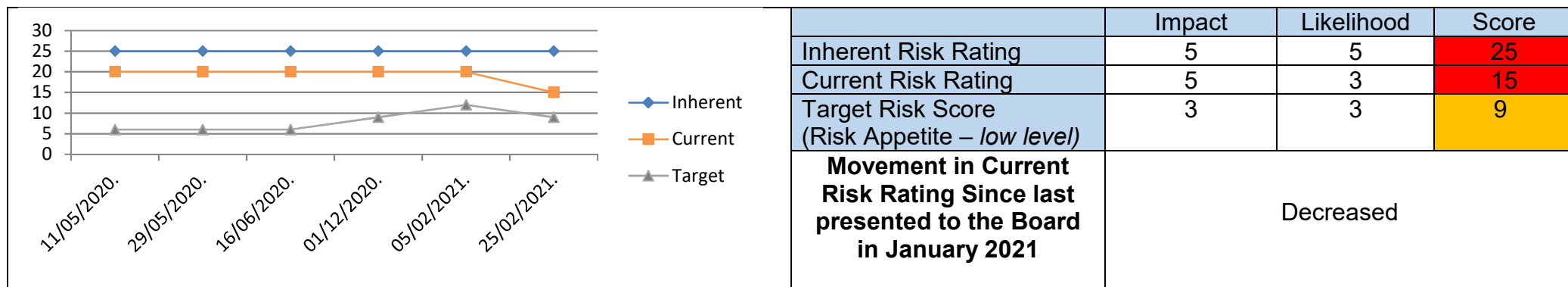
Controls in place	Assurances
1. Fire risk assessments in place (refer to further action 15036). 2. Evacuation routes Identified and evaluation drills established and implemented. 3. Fire Safety Policy established and implemented. 4. Fire Engineer regularly monitor Fire Safety Systems. 5. Fire Safety Mandatory Training and Awareness session regularly delivered to BCUH Staff. 6. Fire Warden Mandatory Training established and being delivered to Nominated Fire Warden.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Committee.

Links to	
Strategic Priorities	Principal Risks
Effective use of our resources Safe, secure & healthy environment for our people	BAF20-15 BAF20-20

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12273	Review Internal Audit Fire findings and ensure all actions are taken.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Governance actions completed and operational elements are captured within the gap analysis areas below.	
	12274	Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Complete with escalation through Hospital Management Teams, Area Terms and MH&LD management teams with site responsible persons.	
	12275	Identify how site specific fire information and training is conducted and recorded.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Database located within the fire safety files, managed and updated by the fire safety trainer.	
	12276	Consider how bariatric evacuation training - is undertaken define current plans for evacuation and how this is achieved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Work in progress. To be included in site specific manual and training developed with Manual Handling team.	
	12279	AlbaMat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Albac mat training is undertaken as part of the induction programme for clinical staff and as part of the refresher-training programme delivered by the Manual Handling team.	
	12554	Commission independent shared services audits.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Independent, Shared Services (Specialist Estates Services) audits commississioned on an annual basis to ensure the appropriate fire safety measures, process and procedures are in	

					place within Acute and Community hospital sites.	
	12555	Information from unwanted fire alarms and actual fires is collated and reviewed as part of the fire risk assessment process.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Unwanted Fire signals (Uwfs) and fire safety data collated within an All-Wales management system and annual report collated and published. Details shared with the SOH&SG and escalated to QSE as necessary. Information reviewed as part of the annual Fire Risk Assessment process and appropriate action taken.	
	15036	Fire Risk Assessments in place Pan BCUHB	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Improve safety and compliance with the Order.	

CRR20-05	<b>Director Lead:</b> Director of Primary and Community Care	<b>Date Opened:</b> 11 May 2020
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee	<b>Date Last Reviewed:</b> 25 February 2021
	<b>Risk:</b> Timely access to care homes	<b>Date of Committee Review:</b> 2 March 2021
		<b>Target Risk Date:</b> 30 June 2021
There is a risk that there will be a delay in residents accessing placements in care homes and other community closed care settings. This is caused by the need to protect these vulnerable communities from the transmission of the virus during the pandemic. This could lead to individual harm, debilitation and delay in hospital discharges impacting on quality of care, wider capacity and patient flow.		



Controls in place	Assurances
<ol style="list-style-type: none"> <li>Multi-agency care home cell established as part of the emergency planning arrangements.</li> <li>PPE distribution system operational including identification and support for residents with aerosol generating procedures.</li> <li>Testing for residents and staff in place aligned with national guidance.</li> <li>Unified “One contact a day” data gathering from care homes established with 6 Local Authorities.</li> <li>Systems for Access to specialist advice via Public Health Wales and the Environmental Health Teams in place to manage isolation and outbreaks.</li> <li>Personalised care and support plans promoted led by specialist palliative care team.</li> <li>New arrangements in place for the timely provision of pharmacy and medication support at the end of life.</li> <li>Remote consulting offered by general practice.</li> <li>Home first bureaus established by the 3 area teams to facilitate sensitive and collaborative decision making on hospital discharge, transfer between care homes and admissions from home.</li> <li>Regular formal communication channels with care homes at a local level and across BCU.</li> </ol>	<ol style="list-style-type: none"> <li>Oversight via the Care Home Cell which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW).</li> <li>Oversight via Gold and Silver Strategic Emergency Planning.</li> <li>Oversight as part of the Local Resilience Forum via SCG.</li> <li>Oversight by the Recovery Group.</li> </ol>

Links to Strategic Priorities		Principal Risks
Continuing to provide care under 'essential' services & safe stepping up planned care		BAF20-04

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12436	Ensure that all new national guidance on testing for care home staff and residents is widely communicated and implemented.	Ms Jane Trowman, Associate Chief of Staff - Operations	31/01/2021	Action Closed 30/01/2021 - Ongoing weekly reviews	
	12437	Continue to refine and develop communication with care homes at a local level and across North Wales.	Ms Jane Trowman, Associate Chief of Staff - Operations	31/01/2021	Action Closed 30/01/2021 - Daily calls made. Twice weekly meetings continue with Care Forum Wales, CIW and partners. Weekly national briefings circulated supplemented by local information.	
	14936	Establish separate discharge cell.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	
	14937	Develop a BCU wide approach to primary care support and intervention, including GPOOH.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will improve communication and support direct admission to care homes.	

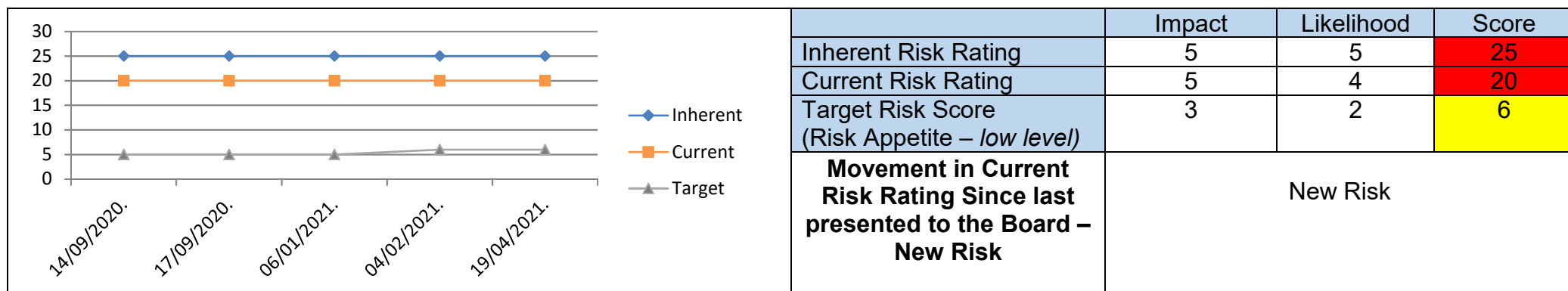
	14938	Develop electronic daily reporting metrics.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	
	14939	Complete and implement a North Wales care home escalation and support tool.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	
	14940	Ensure that all new national guidance on testing for care home staff and residents is widely communicated and implemented.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Ongoing weekly reviews will ensure that regular guidance is shared and implemented to reduce the risk likelihood of the risk re-occurring.	
	14941	Embed the new ways of working in all home first bureau.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	
	14942	Develop communication with care homes at a local level and across North Wales.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	
	14943	deliver a revised financial support package for care homes.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This action will support access to care homes.	

	14944	Adopt care home DES for primary care.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	
	14945	Increasing the frequency for multiagency care home cell.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will improve communication and support direct admission to care homes.	
	14946	Update the 2020 care home monitoring levels and escalation framework.	Kathryn Titchen, Commissioning Manager CHC	30/04/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	
	14947	Development of proactive risk triggers.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	
	14948	Diversion of CHC priorities.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	
	14949	Development of resources support capacity and demand for care homes.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	

	14951	Increase MDT Care Home group to weekly.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	
	14952	Implementation of reactive support to in crisis care homes.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	
	14954	contribute to the development and implementation of national guidance.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	
	15273	Vaccination of Care Home Staff.	Ms Jane Trowman, Associate Chief of Staff - Operations	30/04/2021	Action Closed 25/02/2021 - High uptake of the vaccination will reduce the spread of covid within the care home, if staff are positive then vaccination will reduce the severity of the illness relieving staffing pressures. Process for new staff to access the vaccine in a timely way	



CRR20-08	<b>Director Lead:</b> Executive Director of Nursing and Midwifery	<b>Date Opened:</b> 14 September 2020
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee	<b>Date Last Reviewed:</b> 19 April 2021
	<b>Risk:</b> Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	<b>Date of Committee Review:</b> 02 March 2021
		<b>Target Risk Date:</b> 28 February 2022
There is a risk that patients may come to harm of permanent vision loss. This may be caused by reduced capacity resulting from Covid-19 and increase in waiting times for clinic review as clinics have been cancelled.		
This may negatively impact on patients through untreated proliferative diabetic retinopathy, untreated glaucoma, untreated age related macular degeneration, prolonged suffering and may result in falls from impaired vision due to lack of cataract secondary capacity due to prolonged surgical capacity reduction during the pandemic. This could negatively also impact on patient safety and experience, the quality of care, finance through claims, and the reputation of the Health Board.		



Controls in place	Assurances
<ol style="list-style-type: none"> <li>1. Reviewing list of patients affected to get fast-track or book those who may deteriorate to clinics.</li> <li>2. Cataract - All cataracts have been stratified in order of visual impairment, to deal with the most clinically pressing cases first.</li> <li>3. Once surgery resumes across all sites patients who are already clinically prioritised may be shared across all three units in North Wales to ensure equity of access as part of the 'Once for North Wales' process.</li> <li>4. More clinic slots are being made available to accommodate clinically pressing patients.</li> </ol>	<ol style="list-style-type: none"> <li>1. Risk is regularly reviewed at local Quality and Safety meetings.</li> </ol>
Links to Strategic Priorities	Principal Risks

Continuing to provide care under 'essential' services & safe stepping up planned care	BAF20-03 BAF20-05
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Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14907	Age related macular degeneration – A business case is awaiting approval to increase staffing and treatment capacity. The resources have been identified in the HBs Annual Business Plan for 2021/22 and is being progressed to final approval stages	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to robustly mitigate and manage this risk to its target score.	
	14908	The retinal cameras have been procured as part of a larger equipment replacement scheme and are expected to be commissioned soon. Date awaited from internal sources.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to effectively mitigate and manage this risk so as to achieve its target score.	
	15662	Proliferative diabetic retinopathy – Pan BCUHB pathway has been initiated to get optometry review of the backlog. Referrals are being sent out from secondary care to primary care optometrists and are at various stages of progression but positive progress	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to appropriately mitigate and manage this risk in attaining its target score.	

## Appendix 3b – Operational Risks for Escalation

Appendix 25 – Operational Risk for Escalation		
1925	<b>Director Lead:</b> Executive Medical Director	<b>Date Opened:</b> 10 November 2017
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee Quality and Safety Group	<b>Date Last Reviewed:</b> 19 April 2021
	<b>Risk:</b> Potential harm to patients arising from delays in patient IVT treatment.	<b>Date of Committee Review:</b> New Risk
		<b>Target Risk Date:</b> 29 December 2023
There is a risk that patients may not receive IVT treatment within the target 2 weeks from referral in accordance with NICE guidance, local protocols and best practice. This is caused by a tenfold increase in demand since 2008 without appropriate and commensurate increase in capacity as the situation has been further exacerbated by Covid-19. This could lead to a delay of seven weeks and significant clinical impact leading to patient harm with loss of vision, compromise patient safety, non-compliance, reputational damage and poor patient experience.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	5	20
	Target Risk Score (Risk Appetite – low level)	4	2	8
	<b>Movement in Current Risk Rating Since last presented to the Board in - To be populated following approval</b>	New Risk		

Controls in place	Assurances
1. Virtual clinics in place as increasing them as we can. 2. Increased nurse practitioner led injection sessions offered. 3. Ongoing training being offered to nurse practitioners and non-injecting doctor. 4. Adjusted virtual clinics to routine IVT sessions to increase throughout. 5. Two additional ONP under-going IVT training competencies. 6. Additional ongoing IVT weekend sessions have been funded.	1. Risk regularly reviewed at the Ophthalmology triumvirate and Quality & Safety meeting. 2. Risk reviewed at the Secondary Care Quality & Safety meeting.

Links to Strategic Priorities	Principal Risks

# Appendix 3b – Operational Risks for Escalation

Continuing to provide care under 'essential' services & safe stepping up planned care	BAF20-05
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Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14065	Re-purpose the orthopaedic store room and convert it into a second injecting room and subdivide an existing room to make a second consulting room.	Mrs Elaine Hodgson, Deputy Directorate General Manager	26/12/2023	This will help us reduce the risk by enabling us to inject more patients, maintain our current capacity post-covid-19 and thus enable us to attain the target.	
	14066	Business case under consideration with exec Board; will require Treatment room Estates progress, equipment, staffing including admin, nursing and medical and agreement for additional cost pressure relating to pharmacy stock of treatment vials.	Mrs Elaine Hodgson, Deputy Directorate General Manager	26/12/2023	If another room, scanner, consultation room could possibly double capacity, from 12 per session (covid position) 10 sessions per week (120 patients per week). If had full funding with no covid 30 per session – 9 sessions per week (150 per week) and with funding we could see 270 per week in non-covid.	
	15668	Consideration of potential use of regional cataract centre for North Wales.	Mrs Elaine Hodgson, Deputy Directorate General Manager	26/12/2023	Although not very clear at the moment, the expectation is that this could increase capacity and help mitigate the likelihood of risk.	



<b>Cyfarfod a dyddiad: Meeting and date:</b>	Quality, Safety and Experience Committee 4 <sup>th</sup> May 2021
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public
<b>Teitl yr Adroddiad Report Title:</b>	Annual Assurance Report on compliance with Nurse Staffing Levels (Wales) Act 2016 Three Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act 2016
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Gill Harris, Executive Director of Nursing & Midwifery
<b>Awdur yr Adroddiad Report Author:</b>	Debra Hickman, Secondary Care Nurse Director
<b>Craffu blaenorol: Prior Scrutiny:</b>	The designated person has the responsibility of presenting an Annual Assurance report to the Board.  Staffing Breaches and Harms are reported quarterly via the Secondary Care Quality and Safety group (QSGs) by each Site Director of Nursing through to the Patient Safety Quality Group with escalation of significant issues reported via QSG.
<b>Atodiadau Appendices:</b>	Appendix 1 – CNO Letter, 24 <sup>th</sup> March 2020, clarity on Covid 19 disruption to Nurse Staffing Levels (Wales) Act 2016 Appendix 2 – CNO Letter, 23 <sup>rd</sup> February 2021, Nurse Staffing Levels (Wales) Act 2016 – extension of second duty to paediatric in-patients wards Appendix 3 – CNO letter, 15 <sup>th</sup> October 2020, Update on Covid 19 disruption to Nurse Staffing Levels (Wales) Act 2016 Appendix 4 – Joint statement issued by CNO/Professional bodies Appendix 5 – Establishment outputs
<b>Argymhelliad / Recommendation:</b>	
<p>1. The Committee are asked to note and support the following next steps which are incorporated into the overall Health Board recruitment and retention programme :</p> <ol style="list-style-type: none"> <li>Targeted focus of innovative Nurse recruitment campaigns both locally, nationally and internationally</li> <li>Succession planning for the future, ensuring we are developing our next generation leaders</li> <li>Creatively co-designing our post graduate programmes as key attractors</li> <li>Analysing workforce data to better inform Nurse recruitment and retention initiatives</li> <li>Review of implementation of new roles to support the nursing recruitment pipelines</li> <li>Expansion of quality improvement driven collaborates to assist in reducing variation and harm reduction with a zero tolerance approach</li> <li>Development of a Nurse performance dashboard as a further monitoring and assurance tool in real time</li> </ol>	

h. Further analysis of deviations from previous reporting periods and analysis of the first triennial reporting period of the Act 2. Sharing the outputs of the Nurse Staffing reviews with the Finance and Performance Committee to support changes to the Nurse staffing establishments as presented							
<b>Ticiwch fel bo'n briodol / Please tick as appropriate</b>							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>	✓	<b>Er gwybodaeth For Information</b>	
<b>Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol</b>						<b>N</b>	
<b>Y/N to indicate whether the Equality/SED duty is applicable</b>							
<b>Sefyllfa / Situation:</b>							
In line with the All Wales approach provide assurance to the Health Board with regards to the compliance with the Nurse Staffing Levels (Wales) Act 2016 where by any associated harms are as a result of breaches in Nurse staffing establishments and actions taken to mitigate any risk identified.							
<b>Cefndir / Background:</b>							
<p>The Health Board under section 25a of the Nurse Staffing Levels (Wales) Act 2016 has an overarching responsibility to provide sufficient Nurses to provide timely and sensitive care to patients. The Executive Director for Nursing and Midwifery as Executive lead approves Nurse Staffing reviews ahead of presentation to the Board, having delegated the operational activity as outlined in the Act and referenced in the Health Boards Nurse Staffing policy to the Secondary Care Nurse Director. As part of the triangulated approach special consideration is given to those quality indicators that are particularly sensitive to care provided by a Nurse: Patient falls, Pressure Ulcers, Medication errors and Complaints associated to Nurse staffing and Nursing care as provided in the Assurance report within.</p> <p>The report contains the third Annual Report in the reporting period 5<sup>th</sup> April 2018 – 6<sup>th</sup> April 2021, this being a caveated report due to the timeline of reporting and the closure of incidents in line with reporting timeframes. Included is the first triennial report, which aggregates the 3 annual reports using the All Wales reporting template. For 2018/2019 and 2019/2020 annual reports were presented in May 2019 and July 2020 in line with Section 25E reporting any harms associated as a result of deviations. This is a statutory requirement of the All Wales Nurse Staffing Action (2016) with the reporting period covering 6<sup>th</sup> April 2018 – 5<sup>th</sup> April 2021.</p>							
<b>Asesiad / Assessment &amp; Analysis</b>							
<p>All staffing reviews have been undertaken in line with the Act as referenced in the Health Board's Nurse Staffing policy. These have all been reviewed and approved by the Executive Director of Nursing and Midwifery and presented to the Health Board's designated committee in line with the All Wales reporting calendar.</p> <p>We can confirm mitigating actions have been taken to ensure safe compliance on our Inpatient Adult Acute Medical and Surgical wards, these are referenced in the Health Board Safe Care system. However, we recognise our vacancy levels across the Health Board remain a significant challenge.</p> <p>Increases can be noted in Nursing establishments across all 3 Acute sites with the exception of Ysbyty Glan Clwyd from 2018, however it should be noted that a site refurbishment saw ward footprints reduce in total bed base across all ward areas with the exception of wards 19 &amp; 19a. Similarly there has been an increase in Health Care support worker establishments from 2019/20 onwards with the exception of Ysbyty Wrexham Maelor where increases can be seen from 2018/19. This has been supported by the increase in student commissions, addition of new roles e.g. Band 4</p>							

role and ongoing recruitment – specifically an increase in overseas recruitment in more recent months.

Significant recruitment has been undertaken (both substantive and temporary) as part of the organisational response to the COVID 19 pandemic preparation and also the COVID 19 vaccination programme.

In preparation the Health Board also provided a range of upskilling opportunities for nursing teams, non-clinical staff, allied health professionals and public volunteers which further facilitated the Health Board's response to the first wave of the unprecedented COVID 19 pandemic which has then continued throughout with support from our University colleagues.

Staffing reviews have evolved during the reporting triennial period and now involve a pan-Health Board compare, contrast and professional challenge session involving senior site level and service level representation, peers and external support.

Surge plans were developed in response to the COVID pandemic data modelling issued by Welsh Government, these were monitored alongside actual data and amended accordingly reflecting the staffing position in the Health Board.

The 2021 review and comparisons with previous reviews should be noted with caution due to the number and frequency of wards being repurposed throughout the pandemic and a reduction in bed numbers to ensure social distancing.

However, in the absence of National Acuity data for the Spring 2021 review as per other reviews, evidence available from professional judgement, peer review and safe care suggests themes of patients requiring higher levels of observation due to complex care requirements e.g. cognitive impairment and physical dependency. There has also been an additional impact due to the increase of segregation requirements to ensure patients are appropriately cared for in line with COVID 19 infection prevention guidance. There is also a further emerging pressure on inpatient registered nurse staffing with the requirement to further enhance separation of the inpatient elective pathway, this impact was assessed and recommendations made as part of the staffing review. Also acknowledged is the additional requirements to allow safe donning and doffing during care delivery to patients and the requirement to ensure appropriate fit testing of staff.

All harms have been subject to an incident review 'make it safe' process, learning has informed the work undertaken using the quality improvement collaborates led by the Nursing Quality Team. This work is ongoing and is currently being reenergised with the additional learning acquired during the COVID 19 pandemic. It should be noted that reporting to Welsh Government was reduced during surge periods during the COVID 19 pandemic.

Comparative data between reporting periods shows a decline in incidents between the first and second annual reports for Hospital Associated Pressures Ulcers (HAPUs) and falls with serious harm. The number of medication incidents and complaints are too small to make a statistical analysis of in the first and second annual reports. There has been an increase in the third annual reporting period of both HAPUs and falls in general. Ysbyty Wrexham Maelor and Ysbyty Glan Clwyd report increases in medication incidents with Ysbyty Wrexham Maelor also seeing an increase in complaints which all require further analysis due to the reporting timeframe. We have received reports regards increasing patient dependency via the staffing review process and the impact of

COVID as part of the patient rehabilitation process which noted falls in particular, hence this being a caveated report with a further assurance report to follow once reviews have been completed.

### **Goblygiadau Strategol / Strategy Implications**

Inability to provide appropriate Nurse staffing levels to ensure time to care for patients sensitively can compromise the Health Board's ability to deliver healthcare effectively. One of the most significant challenges of the Covid 19 pandemic was/is making sure there are enough nurses to deliver care sensitively. The joint statement issued by the Chief Nursing Officer (CNO) / professional bodies outlined the expectations of meeting the Nurse Staffing Levels (Wales) Act 2016 requirements within the reality of an abnormal emerging situation using clinical judgment, applying core principles to assess risk and maintain professional standards.

### **Opsiynau a ystyriwyd / Options considered**

Ongoing analysis of recruitment and retention plans.

Improvement collaborates under review as part of the Health Board's Quality Improvement approach.

### **Goblygiadau Ariannol / Financial Implications**

IT support required for real time data to inform early warning approach to quality improvement.

Changes to the nurse-staffing establishment's in-line with the triangulated approach as determined within the Act.

Escalation capacity of which is unfunded and therefore does not support the nurse staffing establishment.

Focus on dedicated recruitment & retention work programme and additional resource to deliver.

### **Dadansoddiad Risk / Risk Analysis**

#### BAF20-25 Impact of Covid 19

There is a risk that the ongoing Covid-19 pandemic will lead to the Health Board being overwhelmed and unable to respond to Covid healthcare needs and/or carry out its core functions due to the spread and impact of Covid-19 in North Wales. This could lead to reduced staff numbers available for work, increased demand on services (including acute, community, mental health and primary care), and suspension of planned services. This could negatively affect patient safety and quality of care, patient outcomes; delivery of the mass vaccination programme and Test, Trace & Protect (TTP); and the Health Board's ability to deliver its plans and corporate priorities.

#### ID 1976: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)

There is a risk to the provision of high quality safe and effective nursing care due to the number of nursing vacancies across the Health Board.

This could be further exacerbated by the impact on the resilience of the workforce due to;

- 1) the ongoing Covid 19 pandemic
- 2) the increasing age profile within the workforce



3) retention rate of nursing staff across the Health Board.

### **Cyfreithiol a Chydymffurfiaeth / Legal and Compliance**

Nurse staff Calculations are presented annually to the Health Board. Changes to ward establishments outside of the Biannual Calculation are approved by the Executive Director of Nursing.

### **Asesiad Effaith / Impact Assessment**

Undertaken as part of the Biannual calculations.

## Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act

## APPENDIX 1

	Betsi Cadwaladr University Health Board
Date annual assurance report with compliance with the Nurse Staffing Levels (Wales) Act is presented to Board	4 <sup>th</sup> May 2021
Reporting period	6 <sup>th</sup> April 2020 -5 <sup>th</sup> April 2021
<b>Requirements of Section 25A</b>  Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels <u>in any area where nursing services are provided or commissioned, not only adult medical and surgical wards.</u>	<p>The Health Board under section 25a of the Nurse Staffing Levels (Wales) Act 2016 has an overarching responsibility to ensure there are sufficient Nurses to provide timely and sensitive care to patients. Although the duty applies to all nursing services within the Health Board including commissioned services, this report references wards outlined in section 25B: all Adult Acute Surgical &amp; Medical inpatient wards. In addition to these areas a calendar of reviews utilising a consistent approach is also in place for the following areas:</p> <ul style="list-style-type: none"><li>• Outpatient departments</li><li>• Admission portals</li><li>• Critical care / High dependency units</li><li>• Theatre areas</li><li>• Procedural units</li><li>• Day case areas</li><li>• Rehabilitation areas</li></ul> <p>The process for review is outlined in the Health Boards Nurse staffing policy <a href="http://howis.wales.nhs.uk/sitesplus/861/page/48259">http://howis.wales.nhs.uk/sitesplus/861/page/48259</a>. The review is commenced at ward level, with scrutiny from the Senior Nursing leadership team, engagement from Workforce and Finance colleagues and final approval provided by the Executive Director of Nursing and Midwifery.</p> <p>It should be noted that in the previous reporting period the Health Board has been informed regards COVID 19 pandemic impact related to: the repurposing requirements of wards to support surge activity, subsequent staffing ratios to maintain services and deferral of acuity audits as per the Acts reporting requirements via SBAR in July 2020. Staffing reviews however have continued, been dynamic in nature to respond to clinical needs of the patients and demand in light of the pandemic, notwithstanding the absence of formal acuity audits. In preparation for Covid</p>

	<p>19, surge plans were developed for anticipated rises in COVID activity supported by daily staffing deployment meetings to respond to the fluid situation presented. Reporting governance structures have been via the Executive led Incident Management Team.</p>
<p><b>Progress to support for suite of workstreams under the All Wales Nurse Staffing Programme</b></p>	<p><i>The Chief Nursing Officer letter of 24<sup>th</sup> March 2020 specifically referenced the disruption that the Covid pandemic would cause to the ongoing work to extend the Act's second duty to paediatric inpatient wards (Appendix 1 – CNO letter, Clarity on Covid 19 disruption to Nurse Staffing Levels (Wales) Act 2016). In October 2020 Welsh Government advised that the coming into force date for the extension has been postponed provisionally until October 2021. The Nurse Staffing Programme Team and the paediatric workstream have devised a suite of supportive mechanisms to prepare Health Boards for the extension of the second duty of the Act. Following a consultation process during the Autumn of 2020, the Statutory Guidance has been revised to include paediatric inpatients. (Appendix 2 – CNO letter, Nurse Staffing Levels (Wales) Act 2016 – extension of second duty to paediatric in-patient wards).</i></p> <p><i>The Health Board has representation on each of the workstream groups within the All Wales Nurse Staffing Programme and is actively contributing to the development of evidence based workforce planning tools in preparation for further extension of the second duty of the Act to other areas in the future.</i></p> <p>The BCUHB Paediatric Nurse Staffing Levels (Wales) Act Implementation Group convened in October 2020 and has been meeting on a monthly basis. Group membership includes Children's Wards Nursing staff, Ward Managers, Matrons and Heads of Children's Nursing, along with Area Director of Nursing, Associate Director for Professional Regulation, Workforce, Finance and Informatics with support as required from the National Project Lead.</p> <p>An action plan has been developed to ensure readiness for the extension of the Act to paediatrics in October this year, ensuring national milestones are met. Staff are currently familiarising themselves with the methodology as the Paediatric Welsh Levels of Care are already well embedded. Both acuity and staffing data is collected on a daily basis with a validation exercise being undertaken to ensure consistency of use across the three inpatient units. A paediatric dashboard is being developed to inform the staffing calculations and allow easy access to the data required to support the triangulated methodology, bringing together acuity, staffing, and quality indicators in a near real time platform for ward managers to access.</p> <p>In August 2021 staffing calculations will be undertaken using the triangulated approach for all our paediatric inpatient areas in readiness for presentation to the Health Board in September 2021. The governance structure for approval and presentation of these calculations is being finalised. Following this, biannual calculations will be undertaken in line with the Adult Acute Surgical and Medical Inpatient areas as defined in Section 25B.</p>

	<p>On finalising the staffing calculations, a business case, if required, will be developed for any additional staffing requirement identified, recognising that the initial work undertaken around staffing establishments has indicated a potential shortfall in current budgets for each area recognising that it may not be possible to fully meet revised staffing establishments at the point of extension of the Act. Paediatric escalation plans and business continuity plans are under review to ensure appropriate mechanisms are in place to meet staffing requirements in the interim period.</p> <p>Future commissioning of nurse education placements has taken in to account the potential requirements for additional staffing to meet the requirements of the extension of the Act. Work is ongoing to operationalise reporting arrangements to meet the requirements of the Act and will be completed prior to October 2021.</p>
<p><b>Actions taken in relation to calculating the nurse staffing level on section 25B wards during the reporting period.</b></p> <ul style="list-style-type: none"> <li>• <b>Adult acute <u>medical</u> inpatient wards</b></li> <li>• <b>Adult acute <u>surgical</u> inpatient wards</b></li> </ul>	<p><i>The normal process by which the Board would receive the annual assurance report was disrupted by the Covid-19 pandemic. The Chief Nursing Officer for Wales issued a formal letter on the 24 March 2020 to provide Health Boards and Trusts with clarity and assurances around how Covid-19 pressures would disrupt the business as usual processes of the Nurse Staffing Levels (Wales) Act 2016 (NSLWA). (Appendix 1 – CNO letter, Clarity on Covid 19 disruption to Nurse Staffing Levels (Wales) Act 2016). Welsh Government left it to the discretion of each Health Board to decide whether to proceed or cease work on the bi-annual recalculation of adult medical and surgical wards. In accordance with the ‘Once for Wales’ approach Nurse Directors agreed that their organisations would defer the bi-annual audit and subsequent calculations of nurse staffing level until July 2020. In April 2020 guidance and templates were issued to Health Boards/Trusts to enable organisations to evidence the approach taken to determine the staffing levels that are required on their inpatient wards where the required staffing level has been affected during the COVID-19 pandemic. The organisation presented a paper to Board in July 2020 to provide assurance on how nurse staffing levels were being/to be calculated and maintained during this period.</i></p> <p><i>In October 2020 The Chief Nursing Officer for Wales issued a follow up formal letter providing further clarity, reflecting the changes organisations had been required to make to patient pathways/ designation of wards across their acute sites, on the definition of wards for inclusion/exclusion under Section 25B of the Act, and the expectations upon Health Boards in relation to calculating the nurse staffing levels in such wards. (Appendix 3 – CNO letter, Update on Covid 19 disruption to Nurse Staffing Levels (Wales) Act 2016).</i></p> <p>With the absence of acuity audits for the Spring review, evidence available from professional judgement, peer review and safe care suggested continued themes of patients higher acuity / dependency with complex care</p>

	<p>requirements such as cognitive impairment and physical dependency. It should also be noted that there is an additional impact due to the increase of segregation facilities to ensure patients are appropriately cared for in line with COVID 19 infection prevention guidance. In addition, this provides a greater challenge regard the segregation of staffing resource to support both COVID and Non COVID pathways safely and effectively. Also acknowledged is the additional requirements to allow safe Donning and Doffing during care delivery to patients and the requirement to ensure appropriate fit testing of staff. As outlined in the joint statement issued by the CNO/Professional bodies. (Appendix 4 – joint statement issued by CNO/Professional bodies).</p> <p>All harms, as per the Act: patient falls, pressure ulcers and medication errors, are subject to a professional review under the ‘Make it safe’ process, learning and actions undertaken to reflect findings and improve quality of patient care. Although it should be noted that during the pandemic formal reporting to Welsh Government in its current form was suspended for periods of time.</p> <p>The Nurse Staffing policy was audited in 2019, whereby several recommendations were made to strengthen the process of calculation and reporting, all of which have now been addressed and completed. The policy has had subsequent revision in 2020 to support outcomes and learning from Nosocomial transmission findings.</p>
<p><b>Using the triangulated approach to calculate the nurse staffing level on section 25B wards</b></p>	<p>The process for determining the Nurse staffing levels at Betsi Cadwaladr University Health Board in this reporting period was as follows:</p> <p>1. Acuity, dependency &amp; occupancy data is collected three times daily and recorded in the Health Boards designated electronic system. The information was used to inform the dynamic assessment of staffing at coordinated intervals daily with mitigating actions taken clearly documented. The dependency data is ordinarily submitted to the All Wales Nurse Staffing group on a bi annual basis for analysis and national benchmarking, recognising deferrals that took place on an All Wales basis as per Appendix 1 – CNO letter, Clarity on Covid 19 disruption to Nurse Staffing Levels (Wales) Act 2016.</p> <p>2. Quality and Professional Judgement (site level) Nurse staffing review meetings took place with Ward Sisters, Matron, Heads of Nursing, Site Directors of Nursing, Workforce and Finance representatives and considered:</p> <ul style="list-style-type: none"> <li>• capacity</li> <li>• current establishments - funded and actual</li> <li>• incidents and subsequent learning</li> <li>• complaints / feedback from staff visitors and stakeholders e.g. students</li> <li>• additional service demands including the impact of care in a pandemic</li> </ul>

	<ul style="list-style-type: none"><li>skill mix</li></ul> <p>3. Quality and Professional Judgement (BCU Acute Site comparison) Reviews were further underpinned with a PAN Health Board compare, contrast and professional challenge session involving senior site level and service level representation, peers and external support. The recommended Nurse establishments for wards included in the scope of section 25B of the act were then reviewed and approved by the Executive Director of Nursing and Midwifery. (Appendix 5, Establishment outputs).</p>										
Informing patients	Information whiteboards display the planned safe staffing requirements at the entry of each ward. These are audited as part of the HBs Ward Accreditation process. Patients have access to bilingual Frequently Asked Questions information leaflets, which includes how to raise concerns about the Nurse Staffing Levels.										
Section 25E (2a) Extent to which the nurse staffing levels are maintained											
As the nurse staffing level is defined under the NSLWA as comprising both the planned roster <i>and</i> the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained <i>and</i> how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.											
The extent to which the nurse staffing levels have been maintained	Period covered	Required establishment (WTE) of S25B wards at the beginning of the annual reporting period. (April 2020)		Required establishment (WTE) of S25B wards calculated during first cycle (May 2020)		WTE of required establishment of S25B wards funded following first (May 2020) calculation cycle		Required establishment (WTE) of S25B wards calculated during second cycle (Nov 2020)		WTE of required establishment of S25B wards funded following second (Nov 2020) calculation cycle	
	2020/2021	RN:	HCSW:	RN:	HCSW:	RN:	HCSW:	RN:	HCSW:	RN:	HCSW:
	YWM	280.69	172.27	230.12	160.99	272.51	195.45	261.34	202.21	272.71	196.45
	YG	250.42	172.17	208.05	144.09	233.69	166.39	231.08	180.54	234.51	165.39
	YGC	268.01	186.21	269.87	210.27	292.32	204.87	244.31	191.29	292.32	204.87

**Accompanying narrative:**

*The number of wards under section 25B is likely to have changed during the reporting period. For more details of individual wards and their calculated nurse staffing levels, refer to the annual assurance reports.*

**Report – July 2020**

<https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/quality-safety-and-experience-committee/quality-safety-and-experience-committee/agenda-bundle-qsec-3-7-20-v2-0-public-session/>

**Report – November 2020**

<https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/quality-safety-and-experience-committee/quality-safety-and-experience-committee/agenda-bundle-qse-3-11-20-public-session-v1-0-reduced-size-pdf/>

Staffing is reviewed on a daily, shift-by-shift basis by the Senior Nursing teams within each of the Acute Sites, all actions / mitigations are recorded in the electronic rostering system. Whereby any consideration of harm because of staffing breaches, these are reported via the HB's incident reporting system – Datix.

As part of the Workforce efficiency streams, ongoing reviews / monitoring have been implemented regards roster and nurse staffing deployment efficiencies, supported by key metrics.

Daily redeployment meetings established during the Pandemic allowed timely escalation, forward planning and a PAN Health Board approach to deploying staff safely and effectively, ensuring 'make safe' mitigating actions to be taken.

A focus on preceptorship programmes for our Newly Qualified staff to aid and support their development and career within the Health Board has received positive feedback.

Recruitment processes continued ensuring timely appointment of new staff, temporary workforce secured in key areas to facilitate consistency and in addition, support from Higher Education Institutes with regards both temporary staff and upskilling were made available. However, we cannot overlook the ongoing challenge regards to Nurse vacancies and the continued focus regards recruitment and retention.

The required establishment should be noted in context of the repurposing of wards and the reduction in bed numbers to support enhanced social distancing and absence of January 2021 formal acuity data collection.

<p><b>Extent to which the nurse staffing levels are maintained within Section 25B wards</b></p>	<p><i>When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E, and health boards were using a variety of e-rostering and reporting systems. During the reporting period 2019/20, all health boards/trusts in Wales worked as part of the All Wales Nurse Staffing Programme to develop a consistent approach to capturing quantitative data on a daily basis (in lieu of a single ICT solution) to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board.</i></p> <p><i>For the 2018/9 and 2019/20 annual reports, this health board - together with all other health boards/trusts in Wales - provided narrative to describe the extent to which the nurse staffing levels have been maintained in order to meet its statutory reporting requirement under Section 25E of the Act.</i></p> <p><i>During the reporting period 2020/21 all health boards/trusts in Wales have begun to implement and use the NWIS delivered enhancements to the NHS Wales Health and Care Monitoring System (HCMS). In light of this development, made available to Health Boards/Trusts across Wales on 1<sup>st</sup> July 2020, organisations have had access to a consistent approach to capturing quantitative data on a daily basis to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board have been maintained in areas which are covered by Section 25B/C of the Act: The limited quantitative data that this approach has provided for 2020/21 for this Health Board is presented and discussed below.</i></p> <p><i>Looking forward, NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. It is anticipated that during the next reporting period (2021-2024) a once for Wales informatics system will be developed and will support Health Boards/Trusts in meeting the reporting requirements of the Act and the Once for Wales approach will ensure consistency. Discussions continue on a national basis to identify the national system and the Nurse Staffing Programme team is working with providers to ensure the system is able to support NHS Wales in collating the data required to inform the reporting requirements.</i></p>
<p><b>Process for maintaining the nurse staffing level</b></p>	<p>The process for maintaining safe Nurse staffing levels are supported by a number of elements of which include:</p> <ul style="list-style-type: none"> <li>• Adult Acute Nurse staffing and Nurse staffing escalation policies are in place and accessible online for staff to refer to which were strengthened as a result of learning post Nosocomial reviews.</li> <li>• Roster optimisation – ensuring that all rosters are completed as per policy and that all rosters are constructed correctly to ensure that the correct number of staff are able to be provided which are underpinned by a suite of roster metrics monitored monthly</li> <li>• Roster approval process – all nurse rosters are subject to a double approval process monitored by the senior nurse team to ensure safe and effective rosters</li> </ul>



- Use of temporary workforce – any gaps that cannot be filled by substantive staff are tendered to temporary workforce solutions, in advance to provide the best opportunities of not only securing the shift but attracting suitably skilled and regular staff
- Streamlined fast track recruitment for internal staff
- Centralised recruitment team to support campaigns for Nurse recruitment supported by Senior Nursing Leadership
- Partnership working with local universities to maximise opportunities for recruitment and retention including innovative opportunities for post graduate development
- New Role developments
- Utilisation of staff survey and student feedback
- During COVID daily staff deployment meetings for escalation, forward look and mitigating actions
- Workforce planning underpinned by the Health Boards Recruitment and Retention strategy

#### Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels

Patients harmed with reference to quality indicators and complaints (*) which are classified as serious incidents and reported centrally <u>NOTE:</u> (*) complaints refers to those complaints made under complaints regulations (Putting	1) Total number of closed serious incidents/complaints during <u>last</u> reporting period	2) Total number of closed serious incidents/complaints during <u>current</u> reporting period.	3) Total number of serious incidents/complaints not closed and to be reported on/during the <u>next</u> reporting period	4) Increase/decrease) in the number of closed serious incidents/complaints between reporting periods (**)	5) Number of serious incidents/complaints where failure to maintain the nurse staffing level was considered to have been a factor



level was not maintained	<ul style="list-style-type: none"> <li>Escalation required regards staffing plan changes were via the Health Board Executive Incident Management Team with approval sought from the Executive Director of Nursing and Midwifery.</li> </ul>
Conclusion & Recommendations	
	<p>As a Health Board there has been underpinning work to secure and assure plans for safe staffing and compliance with the Act to date, of which is ongoing. There is continual development as greater comprehension and information is gained locally and nationally. However, it is also acknowledged that there are further actions that can be undertaken to develop and further assure the process and importantly focus and measure the actual impact of staffing on patient harm.</p> <p>The Board are asked to note and support the following next steps:</p> <ul style="list-style-type: none"> <li>Targeted focus of Nurse recruitment including resource to support campaigns both locally and regionally</li> <li>Development of a clinical fellowship programme for nurses</li> <li>Ongoing analytics regards staff leaving and 'what could we do better?'</li> <li>Review of implementation of new roles to support the nursing recruitment pipeline</li> <li>Expansion of harm avoidance collaborative to assist in reducing variation</li> <li>Development of a nurse performance dashboard as a further monitoring and assurance tool in real time</li> <li>Further analysis of deviations from previous reporting periods</li> <li>Sharing the outputs of the Nurse Staffing reviews with the Finance and Performance Committee to support changes to the Nurse staffing establishments</li> </ul>

## Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act:

### Report for Welsh Government

### APPENDIX 2

<b>Health board</b>	Betsi Cadwaladr University Health Board
<b>Reporting period</b>	<p>The reporting period is 6<sup>th</sup> April 2018-5<sup>th</sup> April 2021. However, due to the timeframe for closing serious incident reports, the three-yearly report that goes to Board in May 2021 will only include data relating to serious incidents closed by 28<sup>th</sup> February 2021.</p> <p>A final, updated version of the report including all serious incident reports that occurred prior to April 5<sup>th</sup> 2021, which should by then be closed, will be presented to the Board and then Welsh Government in September 2021.</p>
<b>Requirements of Section 25A</b>	<p>As per the previous annual reports. The Health Board under section 25a of the Nurse Staffing Levels (Wales) Act 2016 has an overarching responsibility to ensure there are sufficient Nurses to provide timely and sensitive care to patients. Although the duty applies to all nursing services within the Health Board including commissioned services, this report references wards outlined in section 25B: all Adult Acute Surgical &amp; Medical inpatient wards. In addition to these areas a calendar of reviews utilising a consistent approach is also in place for the following areas:</p> <ul style="list-style-type: none"> <li>• Outpatient departments</li> <li>• Admission portals</li> <li>• Critical care / High dependency units</li> <li>• Theatre areas</li> <li>• Procedural units</li> <li>• Day case areas</li> <li>• Rehabilitation areas</li> </ul> <p>The process for review is outlined in the Health Boards Nurse staffing policy <a href="http://howis.wales.nhs.uk/sitesplus/861/page/48259">http://howis.wales.nhs.uk/sitesplus/861/page/48259</a>. The review is commenced at ward level, with scrutiny from the Senior Nursing leadership team, engagement from Workforce and Finance colleagues and final approval provided by the Executive Director of Nursing and Midwifery.</p> <p>It should be noted that in the reporting period of 2020/21 the Health Board was informed regards COVID 19 pandemic impact related to: the repurposing requirements of wards to support surge activity, subsequent staffing ratios to maintain services and deferral of acuity audits as per the Acts reporting requirements. Staffing reviews however have continued, they have needed to be dynamic in nature to respond to the changing capacity demands and clinical needs of the patients in light of the pandemic, notwithstanding the absence of formal acuity audits. In preparation, surge plans were developed for anticipated rises in COVID activity supported by daily staffing deployment meetings to respond to the fluid situation presented. Reporting governance structures have been via the Executive led Incident Management Team.</p>

	2018/2019	2019/2020	2020/2021
<b>Date annual assurance report of compliance with the Nurse Staffing Levels (Wales) Act presented to Board</b>	2 <sup>nd</sup> May 2019	23 <sup>rd</sup> July 2020	4 <sup>th</sup> May 2021
<b>Number of adult acute <u>medical</u> inpatient wards where section 25B applies</b>	YGC 7 YWM 7 YG 7 – became 8 in quarter 3  <a href="#">Annual report 2018 2019</a>	YGC 8 YWM 9 YG 7  <a href="#">Annual report 2019 2020</a>	YGC 8 YWM 9 YG 7  <a href="#">Annual report 2020 2021</a>
<b>Number of adult acute <u>surgical</u> inpatient wards where section 25B applies</b>	YGC 6 YWM 6 YG 5  <a href="#">Annual report 2018 2019</a>	YGC 5 YWM 4 YG 4  <a href="#">Annual report 2019 2020</a>	YGC 4 YWM 4 YG 3  <a href="#">Annual report 2020 2021</a>
<b>Number of occasions where the nurse staffing level recalculated in addition to the bi-annual calculation for all wards subject to Section 25B</b>	YGC 3 YWM 0 YG 2  <a href="#">Annual report 2018 2019</a>	YGC 9 in total, 8 due to Covid (detailed below) YWM 12 in total, 4 due to Covid (detailed below) (+Evington October 20) YG 5 in total, 4 due to Covid (detailed below) and 1 review completed but not changed.  <a href="#">Annual report 2019 2020</a>	YGC 11 in total, all due to Covid (detailed below) YWM 6 in total, all due to Covid (detailed below) YG 2 in total, both due to Covid (detailed below)  <a href="#">Annual report 2020 2021</a>

<b>Changing the purpose of the adult acute medical and surgical wards to support the management of COVID or opening new COVID wards.</b>	<p>YGC</p> <p>Ward 1 Medical – April 2020 Ward 2 Medical – April 2020 Ward 9 Medical – March 2020 Ward 11 Medical – March 2020 Ward 12 Medical – March 2020 Ward 3 Surgical – March 2020 Ward 5 Surgical – April 2020 Ward 6 (ABH) Surgical – March 2020</p> <hr/> <p>Ward 1 Medical – December 2020 Ward 2 Medical – December 2020 Ward 4 Medical – December 2020 Ward 9 Medical – December 2020 Ward 11 Medical – December 2020 Ward 12 Medical – December 2020 Ward 14 Medical – December 2020 DOSA Medical – December 2020 Ward 5 Surgical – December 2020 Ward 7 Surgical – December 2020 Ward 8 Surgical – December 2020</p>	<p>YWM</p> <p>Mason Medical – April 2020 Erddig Medical – April 2020 (up to 5<sup>th</sup>) Bonney Medical – April 2020 Prince of Wales (27 funded) Surgical – March 2020</p> <hr/> <p>Evington Medical – October 2020 Erddig Medical – April 2020 (from 6<sup>th</sup>) Bromfield Medical – March 2020 Bonney Medical – April 2020 ENT Surgical – December 2020 Prince of Wales Surgical – October 2020 + January 2021</p>	<p>YG</p> <p>Aran Medical – April 2020 Dulas Surgical – April 2020 Enlli Surgical – April 2020 Ogwen Surgical – April 2020</p> <hr/> <p>Aran Medical – April 2020 Moelwyn Medical – April 2020</p>
	<ul style="list-style-type: none"> <li>• As Dependency &amp; occupancy data is routinely collected three times a day and recorded in the Health Boards designated system, this information assisted in dynamic assessment of staffing at coordinated intervals throughout each day and the appropriate mitigating actions required given the demand changes experienced. A record of mitigations taken is recorded to provide supporting evidence of staffing management.</li> <li>• Surge plans were developed in preparation for anticipated COVID demand increase, these identified wards that would be repurposed as required with supporting nurse staffing plans which were outlined in SBAR format presented to the Health Board of which were agreed.</li> <li>• Surge plans described above also indicated additional suitable capacity provisions available across the Health Board in existing estate. A separate Executive group undertook the oversight of the development of additional temporary surge capacity in partnership with stakeholders. It should be noted that throughout a significant defining factor was that of staffing.</li> </ul>		
<b>The process and methodology used</b>	The process for determining the Nurse staffing levels at Betsi Cadwaladr University Health Board has three steps:		

<b>to inform the triangulated approach</b>	<ol style="list-style-type: none"> <li>1. Acuity and dependency data is collected for a full month for all wards falling under the concern of the Act. This data is reviewed and validated within the Senior Nurse Leadership Team.</li> <li>2. Upon completion and publication, this data is utilised as part of a triangulated method at local Ward reviews. The triangulation includes the review of a range of Nurse Sensitive Indicators, Professional Judgement using the Chief Nursing Officers guiding principles. The local review meetings are multi-disciplinary and consider factors such as escalation beds, increases in demand and activity and national focus. PAN Health Board review ensures consistency and efficiency of work for utilisation underpinned by national guidance and best practice evidence available at the time of the review.</li> <li>3. A recommendation for the planned staffing establishment for each ward is concluded. Each Hospital Nurse Director verifies this with proposed changes being notified to the designated Secondary Care Nurse Director prior to final approval by the Executive Director for Nursing and Midwifery. For audit purposes, each ward completes the designated proforma available within the 'Nurse Staffing Levels (Wales) Act 2016' Operational Guidance as evidence and to ensure consistency and transparency.</li> </ol> <p>Following the above process, all outcome reviews were presented to the Board on 1<sup>st</sup> November 2018 and subsequently designated Health Board committee QSE 19<sup>th</sup> November 2019 and 3<sup>rd</sup> November 2020, the detailed nurse staffing for each of the designated wards at that time, together with the rationale and recommendations were presented. All nurse establishments include the 26.9% uplift to registrant whole time equivalent posts and ward Sister/Charge Nurses roles have designated supernumerary status.</p>
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### Section 25E (2a) Extent to which the nurse staffing level is maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

achieved/maintained over the reporting period.														
		2017/2018			2018/19			2019/20*			2020/21			
		RN						*required establishment reported within annual report for 2019/2020 was reported as numbers. Required establishment reported below WTE						
Extent to which the required establishment has been maintained within wards under section 25B	Required establishment (WTE) of S25B wards prior to commencement of the Acts second duty (March 2018)	YGC	YWM	YG										
		225.5	218.3	222.2										
		HCSW												
		YGC	YWM	YG										
		183.3	131.3	153.8										
	Required establishment (WTE) of S25B wards calculated during first cycle (May)	RN:	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG
			238.5	230.3	234.2	268.01	280.69	250.42	269.87	230.12	208.05			
		HCSW:	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG
			183.3	131.3	153.8	186.21	172.27	172.17	210.27	160.99	144.09			
	WTE of required establishment of S25B wards funded following first (May) calculation cycle	RN:	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG
			324.34	287.04	224.67	271.95	287.53	236.13	292.32	272.51	233.69			
		HCSW:	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG

**Extent to which the nurse staffing levels are maintained within Section 25B wards**



*During the reporting period 2020/21 all health boards/trusts in Wales have begun to implement and use the NWIS delivered enhancements to the NHS Wales Health and Care Monitoring System (HCMS). In light of this development, made available to Health Boards/Trusts across Wales on 1<sup>st</sup> July 2020, organisations have had access to a consistent approach to capturing quantitative data on a daily basis to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board have been maintained in areas which are covered by Section 25B/C of the Act: The limited quantitative data that this approach has provided for 2020/21 for this Health Board is presented and discussed below.*

*Looking forward, NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. It is anticipated that during the next reporting period (2021-2024) a once for Wales informatics system will be developed and will support Health Boards/Trusts in meeting the reporting requirements of the Act and the Once for Wales approach will ensure consistency. Discussions continue on a national basis to identify the national system and the Nurse Staffing Programme team is working with providers to ensure the system is able to support NHS Wales in collating the data required to inform the reporting requirements.*

The information assists to support a dynamic assessment of staffing at coordinated intervals throughout each day and to inform the management of staffing levels. The dependency data is submitted to the All Wales Nurse Staffing group on a bi annual basis for analysis and national benchmarking.

**Process for maintaining the nurse staffing level for Section 25B wards**

- The process for maintaining safe Nurse staffing levels are supported by a number of elements of which include:
- Adult Acute Nurse staffing and Nurse staffing escalation policies are in place and accessible online for staff to refer to which were strengthened as a result of learning post Nosocomial reviews.
  - Roster optimisation – ensuring that all rosters are completed as per policy and that all rosters are constructed correctly to ensure that the correct number of staff are able to be provided which are underpinned by a suite of roster metrics monitored monthly (daily during COVID surge to inform redeployment decisions)
  - Roster approval process – all Nurse rosters are subject to a double approval process monitored by the senior Nurse team to ensure safe and effective rosters
  - Use of temporary workforce – any gaps that cannot be filled by substantive staff are tendered to temporary workforce solutions, in advance to provide the best opportunities of not only securing the shift but attracting suitably skilled and regular staff on a block basis where possible to aid continuity
  - Streamlined fast track recruitment
  - Centralised recruitment team to support campaigns both targeted and generic for Nurse recruitment locally, nationally and internationally supported by Senior Nursing Leadership
  - Partnership working with local universities to maximise opportunities for recruitment and retention including innovative opportunities for post graduate development
  - New Role developments
  - Utilisation of staff and student feedback

- During COVID daily staff deployment meetings for escalation, forward look and mitigating actions
- Workforce planning informed by the Nurse staffing review process and underpinned by the Health Boards Recruitment and Retention strategy

### Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in Section 25B wards

April 6<sup>th</sup> 2018 – April 5<sup>th</sup> 2021

Patients harmed with reference to quality indicators and complaints (*) which are classified as serious incidents and reported centrally  <u>NOTE:</u> (*) complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR))	Total number of closed serious incidents/complaints during last reporting period	Total number of closed serious incidents/complaints during current reporting period.			Total number of serious incidents/complaints not closed and to be reported on/during the <u>next</u> reporting period			Increase (decrease) in number of closed serious incidents/complaints between reporting periods	Number of (closed) serious incidents/complaints where failure to maintain the nurse staffing level was considered to have been a factor		
<ul style="list-style-type: none"><li>Hospital acquired pressure damage (grade 3, 4 and unstageable).</li></ul>		YGC 63	YWM 80	YG 93	YGC 4	YWM 1	YG 10		YGC 0	YWM 0	YG 2
		Total 236			Total 15				Total 2		

<ul style="list-style-type: none"> <li>Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).</li> </ul>		YGC	YWM	YG	YGC	YWM	YG		YGC	YWM	YG
		51	50	68	1	2	4		3	1	1
		Total 169			Total 7				Total 5		
<ul style="list-style-type: none"> <li>Medication related never events.</li> </ul>		YGC	YWM	YG	YGC	YWM	YG		YGC	YWM	YG
		3	12	3	1	0	0		0	0	0
		Total 18			Total 1				Total 0		
<ul style="list-style-type: none"> <li>Complaints about nursing care resulting in patient harm (*) (*) This information is not required for period 2018/19</li> </ul>		YGC	YWM	YG	YGC	YWM	YG		YGC	YWM	YG
		4	10	1	0	0	0		0	0	0
		Total 15			Total 0				Total 0		

#### Section 25E (2c) Actions taken if nurse staffing level is not maintained

<b>Actions taken when the nurse staffing level was not maintained in Section 25B Wards</b>	<ul style="list-style-type: none"> <li>An SBAR was presented to QSE in July 2020 outlining the staffing plans in light of Pandemic surge impact, this also described the potential impact regards staffing ratio changes to meet anticipated demands</li> <li>Nurse staffing surge plans were created using a risk based approach reviewing all services whereby Nursing care is provided including commissioned services, of which were approved by the Health Board</li> <li>Escalation regards staffing changes as described in the surge plans were via the Health Board Executive Incident Management Team with approval from the Executive Director of Nursing and Midwifery</li> </ul>
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## Conclusion & Recommendations

As a Health Board there has been underpinning work to secure and assure plans for safe staffing and compliance with the Act to date, of which continues to develop and evolve. There is continual learning as greater comprehension and information is gained locally and nationally. However, it is also acknowledged that there are further actions that can be undertaken to develop and further assure the process and importantly focus and measure the actual impact of staffing on patient harm. The previous annual reporting period has provided significant challenge in the light of pandemic, of which were further enhanced by the Nurse vacancy position.

The Board are asked to note and support the following next steps:

- Targeted focus of innovative Nurse recruitment campaigns both locally, nationally and internationally informed by workforce data/analysis and feedback
- Succession planning for the future, ensuring we are developing our next generation leaders
- Creatively co-designing our post graduate programmes as key attractors supporting the University status held by the Health Board
- Analysing workforce data to better inform Nurse retention initiatives
- Review of implementation of new roles to enhance and develop nursing recruitment pipelines
- Expansion of quality improvement driven collaborates to assist in reducing variation and harm reduction with a zero tolerance approach
- Development of a Nurse performance dashboard as a further monitoring and assurance tool in real time
- Further analysis of deviations from previous reporting periods
- Sharing the outputs of the Nurse Staffing reviews with the Finance and Performance Committee to support changes to the Nurse staffing establishments

## **Appendices**

### 2018/2019 Annual Report

<https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-meetings/health-board-meetings/agenda-health-board-2-5-19/>

### 2019/2020 Annual Report

<https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-meetings/health-board-meetings/agenda-bundle-health-board-23-7-20-public-v1-0-pdf/>

### 2020/2021 Annual Report

Health and Social Services Group  
Y Grŵp Iechyd a Gwasanaethau Cymdeithasol  
Prif Swyddog Nyrsio - Cyfarwyddwr Nyrs GIG Cymru  
Chief Nursing Officer - Nurse Director NHS Wales



Llywodraeth Cymru  
Welsh Government

To: NHS Executive Nurse Directors

24 March 2020

Dear Colleagues,

### **Clarity on COVID19 disruption to Nurse Staffing Levels (Wales) Act 2016**

As COVID19 has become an established and significant epidemic across the UK, NHS Wales' staff and services are coming under increasingly extreme pressure. Welsh Government is fully aware that any sense of "*business-as-usual*" is becoming increasingly untenable.

I want to provide you with clarity and assurances around how I expect these additional pressures will disrupt the business-as-usual processes of - and work-streams associated with - the Nurse Staffing Levels (Wales) Act 2016 (*the Act*).

It will be helpful to consider the effects of the COVID19 pressures under two headings: firstly the ongoing work to extend the Act's second duty to paediatric inpatient wards; and secondly, compliance with and reporting against the existing duties under the Act.

### **Extending the second duty to Paediatrics**

Thus far, the provisional schedule for this work has been as follows:

- June to August 2020: 3 month public consultation on the draft regulations and amended statutory guidance;
- November 2020: regulations laid before the Senedd;
- December 2020: Senedd debate and presumptive passing of regs;
- April 2021: Coming-into-force date of regulations on paediatric inpatient wards.

The timetable of those processes is now clearly compromised. In terms of the legislative steps, the capacity to undertake the drafting requirements is still available within Welsh Government. We intend to reschedule the plenary debate to February 2021, allowing the consultation to take place later in 2020, several months after the projected peak of COVID19 activity.

The remaining issue is the capacity within the health boards to take the necessary actions to prepare their wards and staff for the introduction of the new regulations. April 2021 now appears to be entirely unfeasible as a coming-into-force date. Given the current timescales, it is a fair assumption that health boards will require approximately 12 months of preparation time under normal circumstances before the regulations could come into force. In the context of this work stream, I consider *normal circumstances* to be suspended.

However a final decision on a coming-into-force date won't need to be made until the regulations are laid before the Senedd in early 2021. We will of course be monitoring the COVID19 pressures intently in the coming weeks and months, and it is my intention that the 12 month countdown on necessary preparation time for health boards will not resume until pressures have subsided significantly enough to allow this work-stream to continue. For example, if by October 2020 we have returned to what could be considered more "normal circumstances", we would then target a coming-into-force date of October 2021.

This approach is of course based on the best currently available evidence and projection, and is subject to change if and when the situation evolves. Should our approach change in any way, I will of course update you immediately.

Also linked to the extension to paediatric inpatients, I am conscious that our second planned data capture around compliance with the interim paediatrics principles is due this coming May. For obvious reasons I have taken the decision to postpone this until November, pending any further developments.

### **Summary**

- Welsh Government will proceed with the legislative steps that will allow extension of the Act's second duty within this government term as committed.
- This will be achieved through delaying the public consultation to late 2020 and the plenary debate to early 2021.
- The planned April 2021 coming-into-force date will be postponed based on at what point health boards have returned to normal enough circumstances to reasonably proceed with the necessary preparations for extension of the Act's second duty into paediatric inpatient wards.

### **Compliance with and reporting against the existing duties under the Act**

Broadly, the duties on health boards currently under the Act are as follows:

- to calculate nurse staffing levels for adult medical and surgical wards using a prescribed triangulated methodology;
- to take all reasonable steps to maintain those calculated nurse staffing levels;
- to produce a three-yearly report to Welsh Ministers (May 2021) on the extent to which nurse staffing levels have been maintained and the impact not maintaining them has had on care.
- to have regard to providing sufficient nurses wherever nursing care is provided or commissioned;

### **Calculation**

The wording of the statutory guidance is that health boards *should* undertake a recalculation every six months rather than *must*. There is an important legal distinction between the two. If "must" had been used, the biannual calculation schedule would be absolutely mandatory, and we would either need to consider suspending that guidance or accept that all health boards would be non-compliant with the Act. However, "should" allows for more discretion and flexibility in extraordinary circumstances. With the next biannual calculation due imminently, you will need to ask serious questions about whether the resource that goes in those calculations is better used elsewhere.

Further, there is a question around on which wards the health boards would actually be using that triangulated calculating methodology given that we expect ward purposes to change dramatically, and at a rapid pace. On the Executive Nurse Directors Skype meeting on Wednesday last week, you were united in your view that by the peak of the Covid19 pressures, it is likely that all of your currently designated adult medical and surgical wards

will have become “*Covid wards*”. Those wards would technically be considered medical in nature, however given that they will be entirely novel, the lack of quality indicator information alone would make it impossible for you to perform the triangulated calculation as prescribed. There is also a fundamental question of whether the *Welsh Levels of Care* evidence-based workforce planning tool could be applied in those wards given that they will be significantly different environments to the business-as-usual medical and surgical wards where the tool was tested for 2 years.

#### Maintaining Nurse Staffing Levels

It is safe to say that during the additional Covid19 pressures, maintaining the nurse staffing levels that have been calculated on your adult medical and surgical wards will become an impossible challenge. Your workforces are likely to be reduced by sickness, and significant numbers of the available nursing staff will be redeployed to Covid19 response out of necessity.

However, we must bear in mind that varying from the nurse staffing level does not constitute a lack of compliance with the Act. As long as a ward remains designated as an adult medical or surgical ward, you will still be actively applying your professional judgement and taking all reasonable steps to mitigate the risk to patients on those wards. Indeed, closing those wards entirely is a reasonable step available to you if you deem it necessary. It is not a step we envisaged being commonly implemented when writing the legislation, but this public health crisis is in essence the most extreme test of the flexibility built into the Act.

#### Reporting

I am aware that you are due to take annual reports to your boards in May. I am also mindful that those annual reports are a voluntary step that you as a group of peers agreed to on an all-Wales basis rather than something that is mandated within the Act or its statutory guidance. In usual circumstances it is eminently sensible to provide annual assurances to your Boards that can then be aggregated to create the 3-yearly reports to Welsh Government. However in these extraordinary circumstances, you need to decide whether the time and resource necessary to produce those reports would not be more valuably redirected elsewhere.

In terms of the 3 year report (due in May 2021) which is a statutory requirement, the disruption caused by this pandemic will inevitably have a dramatic impact on the contents of those reports. Thanks to the work of the All Wales Adult work-stream of the Nurse Staffing Programme, we now have a consistent approach to meeting the reporting requirements of the Act. However, a key part of that approach involves enhancements to the HCMS system, which will be impacted by the additional Covid19 pressures. The timescale for delivery was initially 1 April, though I understand that has slipped by a week according to our last update. Whether the enhancements are delivered in April or not, it does not seem reasonable to ask frontline nurses to adopt a new process during what will be a national staffing emergency.

What will be important during these coming months, is that careful records are kept of the steps that you take to manage this developing situation. In April 2021, the first 3-year reports will look significantly different to how we would have envisaged at the start of this year. However, you will still be required to recount the story of what happened on your wards, for example, on what date you closed particular medical and surgical wards to repurpose them as Covid19 wards.

#### Overarching regard for providing sufficient nurses

Your duty under section 25A of the Act will remain an important factor in how you are deploying your nursing staff across the entirety of your health boards wherever nursing care is provided or commissioned. Even during a period where “providing sufficient nurses” will



seem like a foreign concept, your responsibility of minimising risk to patient safety through applying your professional judgement will remain.

### **Summary**

Under these exceptional circumstances, it is the Welsh Government's position that:

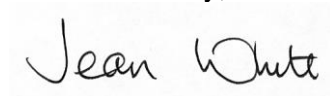
- it is within the health boards' respective discretion to proceed with or cease work on the imminently scheduled biannual re-calculation of adult medical and surgical wards;
- similarly it is within the health boards' respective discretion to indefinitely postpone the annual report to board, due May 2020;
- adult medical and surgical wards that have been repurposed as novel wards to deal with the Covid19 pandemic would be considered an exception under the definition of an adult medical ward, therefore would not be subject to the prescribed triangulated calculation methodology;
- as long as wards remain designated as adult medical and surgical wards, health boards will be expected to persist with taking all reasonable steps to maintain calculated nurse staffing levels and undertake the usual mitigating actions where possible;
- we acknowledge that those reasonable steps and mitigating actions are still likely to fall short of enabling health boards to maintain the Nurse Staffing Levels calculated during usual circumstances;
- health boards should ensure that they take whatever steps they deem necessary to record their actions taken over the coming months in order to adequately articulate within the first three-year report (due April 2021) the narrative of these extraordinary circumstances;
- health boards – through their executive nurse directors - ensure they are informed of actions being taken in other health boards, and that a consistent, collaborative approach is taken by all; and
- your professional judgement as designated persons will remain a key determinant in ensuring staffing in all areas where nursing care is either provided or commissioned is managed as appropriately as possible during an extraordinarily difficult time.

Finally, I feel I must stress the importance of remaining united as a peer group. Especially in such extraordinary times, there is clear value to a once-for-Wales approach to how health boards manage these immense pressures.

A hoffech gael yr wybodaeth hon yn  
Gymraeg, byddwch cystal â rhoi gwybod.

If you would like to receive this information in  
Welsh, please let me know.

Yours sincerely,



Professor Jean White CBE  
Chief Nursing Officer  
Nurse Director NHS Wales

Health and Social Services Group  
Y Grŵp Iechyd a Gwasanaethau Cymdeithasol  
Prif Swyddog Nyrsio - Cyfarwyddwr Nyrs GIG Cymru  
Chief Nursing Officer - Nurse Director NHS Wales



Llywodraeth Cymru  
Welsh Government

**To:** NHS Wales Executive Nurse Directors  
NHS Wales Chief Executive Officers

23 February 2021

Dear Colleagues,

**Nurse Staffing Levels (Wales) Act 2016 – extension of second duty to paediatric in-patients wards**

I am pleased to inform you that Senedd Cymru has today passed the *Nurse Staffing Levels (Extension of Situations) (Wales) Regulations 2021*. I wanted to formally write to you to set out what this extension of duty means for your organisations and to articulate the precise timetable of the associated obligations.

These regulations merely extend the duties under section 25B of the Act to include paediatric inpatient wards. The simplest way to put it is that the actions you have already been taking on your adult acute medical and surgical inpatient wards since April 2018 will now also need to be applied to your paediatric wards. Due to the disruption of the COVID19 pandemic, these regulations will come into force on 1 October 2021. Below is a timetable of the major pieces of associated work falling out of this extension:

Milestone	Due date
Undertake first triangulated calculations of nurse staffing levels for paediatric inpatient wards	Aug 2021
Present calculated nurse staffing levels to Board	Sept 2021
Regulations come into force – newly calculated nurse staffing levels and accompanying patient information-boards to be in place on wards	1 Oct 2021
First annual assurance report to board	May 2022
First three-year report to Welsh Government	May 2024

You will note that despite not going live until October, the reporting dates have remained aligned with the existing reporting schedule for adult acute medical and surgical wards. This is due to the fact that the three-year reporting period is tethered to the date of the Act's commencement, not the coming-into-force date of these regulations. In practice, this means you will present papers on your paediatric wards at the same time as papers for your adult wards – though the first annual report and three-yearly report on paediatric wards will of course be missing the first six months of the period.

More detail on all of these practical steps will be published in the operational guidance document that is currently being prepared by the paediatric work-stream of the All Wales Nurse Staffing Group. I envisage this will be completed and circulated to you by early summer. It is also worth noting that the paediatric work-stream will play the same pivotal

role of ensuring a once-for-Wales approach to implementing these duties as the adult work-stream has done for the last three years. It is critically important that all health boards have strong and consistent representation on these groups. I am grateful to Ruth Walker, Jo Doyle, Jason Roberts, Sian Passey and Dawn Parry for their ongoing work in supporting the real-world application of this pioneering legislation.

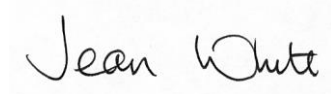
As discussed in our Nurse Directors hot topics call of 12 February, we will not proceed with the next interim paediatric nurse staffing principles return scheduled for May 2021. As the name suggests, these principles were only ever intended as a bridging stop-gap until the Act's second duty could be extended, at which point they will be obsolete. Given the inevitable residual staffing pressures due to the COVID10 pandemic and the limited value of obtaining data that will soon be irrelevant, there was unanimous agreement on our call that proceeding with the audit would not be a worthwhile use of resources.

That being said, I want to remind you about the importance of comparative data for this work. You will need to ensure that you record the nurse staffing establishments for your paediatric wards *before* the first triangulated calculations under the Act come into force. The three-year reporting template due in May 2024 will require this information, so it would be wise to plan for that now rather than retroactively trying to locate the information three years down the line. It will also be important for articulating the immediate monetary difference that the Act has made to paediatric nurse staffing in Wales which is a question likely to be asked of us at the end of this year. Therefore I would ask that you have clear records of the nursing establishments on your paediatric wards at the end of September.

A hoffech gael yr wybodaeth hon yn  
Gymraeg, byddwch cystal â rhoi gwybod.

If you would like to receive this information in  
Welsh, please let me know.

Yours sincerely,



Professor Jean White CBE  
Chief Nursing Officer  
Nurse Director NHS Wales

**CC:** Jason.Roberts@wales.nhs.uk  
Sian.m.Passey@wales.nhs.uk  
Joanna.Doyle2@wales.nhs.uk  
Dawn.parry3@wales.nhs.uk

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Prif Swyddog Nyrsio - Cyfarwyddwr Nyrs GIG Cymru  
Chief Nursing Officer - Nurse Director NHS Wales



Llywodraeth Cymru  
Welsh Government

To: NHS Executive Nurse Directors

15 October 2020

Dear Colleagues,

### **Update on COVID19 disruption to Nurse Staffing Levels (Wales) Act 2016**

You will recall that I wrote to you in March of this year as the NHS prepared for the predicted disruption of the Covid19 pandemic. In that letter I set out my expectations of how the pandemic might impact the various duties of the Nurse Staffing Levels (Wales) Act 2016, and stressed the importance of a unified approach across the country.

This included a rationale that wards *repurposed as novel Covid19 wards* would fall outside of the 25B ward definition, and therefore not be subject to the prescribed triangulated methodology. This was of course written early in the spread of the virus, where reasonable worst case scenario projections were describing a near-future where our NHS wards would be predominantly occupied by critically unwell Covid patients, and where field hospital care would be prevalent. Thankfully, those grim projections were not fully realised.

Following a meeting with the Chairs of the All-Wales Nurse Staffing Group and its Adult sub group, it is clear to me that the reality of how wards have been managed in the intervening months has been more nuanced and complex than we initially might have expected.

Understandably, different quarantining protocols and the repurposing of inpatient bed areas have been applied across NHS Wales. These range from: entirely Covid-free wards; wards with Covid-positive patients who are asymptomatic and being treated for other medical or surgical conditions; Covid-positive patients who are symptomatic but not acutely ill from the disease and being treated for other medical or surgical conditions; and wards where all patients are critically unwell with Covid requiring intensive care primarily for that reason.

With the benefit of hindsight of how the first phase of the Covid19 pandemic evolved, I feel that it would be timely to clarify how the lived experiences of the last six months relate to the dispensations outlined in my letter of 24 March. Questions have been raised from an operational perspective whether – for example – a ward with asymptomatic Covid-positive patients not being treated for Covid-related illness would be exempt from the 25B definition. The most concise way to answer this is to refer back to the Statutory Guidance of the Act where the definitions of adult acute medical and surgical wards apply “*according to the primary purpose of the ward*”.

If the primary purpose of a ward remains the treatment of patients for medical or surgical conditions, and the Welsh Levels of Care tool is still applicable to that setting, then in my view those wards would remain under the auspices of 25B of the Act.

Conversely, if a ward was legitimately repurposed to treat those critically unwell Covid19 patients - as we expected in March to be a more common occurrence – my view would



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MEWN POBL | IN PEOPLE

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Jean.white@gov.wales  
Gwefan • website: [www.wales.gov.uk](http://www.wales.gov.uk)

remain that those wards would be considered exclusions with an expectation you would follow national advice on staffing critical care areas.

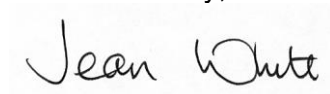
On 1 July 2020, an updated version of the Healthcare Monitoring System (HCMS) went live for use. Informed by the All-Wales Adult work-stream, the enhancements were designed to support health boards in recording data that the Act lists as being necessary under section 25E (reporting). With this in mind, I would expect to see the beginnings of a more detailed reporting picture from 1 July 2020 than had previously been possible. I do appreciate that the disruption caused by Covid19 will not have created the optimum conditions for the roll-out of this updated system, but I hope that you have instructed your senior staff on the importance of ensuring that the data are being captured as accurately as possible as this will inform the first public 3-year report due in May next year.

Finally I want to thank you for your focus and hard work over the last six months. With the winter approaching and a second peak of Covid infections coming with it, you will be required to display the same resolute character and professionalism in the face of potentially greater adversity than the NHS has endured so far this year. I hope this letter provides the clarity and support you will need to be able to capture the nurse staffing story in a consistent way to inform next year's reports. I would also like to remind you of the portions of my 24 March letter that highlighted the various areas of work where the Act gives health boards the discretion to make decisions on whether or not to undertake certain processes. As we approach another period that may well bring unprecedented pressures, I want to be clear that those discretionary provisions are still relevant. All I would ask – once again – is that you make those decisions together as a peer group, and take a unified approach where possible and appropriate.

A hoffech gael yr wybodaeth hon yn  
Gymraeg, byddwch cystal â rhoi gwybod.

If you would like to receive this information in  
Welsh, please let me know.

Yours sincerely,

A handwritten signature in black ink that reads "Jean White". The signature is written in a cursive, flowing style.

Professor Jean White CBE  
Chief Nursing Officer  
Nurse Director NHS Wales



12 March 2020

Dear colleagues

### **Supporting Nurses and Midwives across the UK and Nursing Associates (England only) in the event of a COVID-19 epidemic in the UK**

Let us start by thanking you, we know that you and your colleagues have been working exceptionally hard, and you should know that the work you are doing is having a real impact.

If COVID-19 becomes an established significant epidemic in the UK, NHS services across the health and care sectors will be put under extreme pressure. This pressure will inevitably be exacerbated by staff shortages due to sickness or caring responsibilities. It will be a challenge, but we are confident that nursing and midwifery professionals will respond rapidly and professionally. We want to assure colleagues that we recognise this will require temporary changes to practice, and that regulators and others will take this into account.

A significant epidemic will require health and care professionals to be flexible in what they do. It may entail working in unfamiliar circumstances or surroundings or working in clinical areas outside of their usual practice for the benefit of patients, individuals and the population as a whole. This can be stressful, and we recognise that you may have concerns about both the professional practicalities and implications of working in such circumstances.

We need to stick to the core principles of nursing and midwifery practice. As registered professionals you are expected to practice in line with the NMC code and use judgement in applying the principles to situations that you may face. However, these also take account of the realities of a very abnormal emergency situation. We want nursing and midwifery professionals in partnership with patients and those individuals that we care for, to use their professional judgement to assess risk and to make sure people receive safe care, informed by the values and principles set out in their professional standards. A rational approach to varying practice in an emergency is part of that professional response.

It is the responsibility of the organisations in which you work to ensure that you are supported to do this. They must bear in mind that clinicians may need to depart, possibly significantly, from established procedures in order to care for patients in the unique and highly challenging but time-bound circumstances of the peak of an epidemic.

We expect employers, educationalists, professional bodies and national NHS organisations to be flexible in terms of their approach and the expectations of routine requirements. Health and care professional regulators, including the NMC have already committed to take into account factors relevant to the environment in which the professional is working.

Due consideration should and will be given to health and care professionals and other staff who are using their skills under difficult circumstances due to lack of personnel and overwhelming demand in a major epidemic. This may include working outside their usual scope of practice. The health and care regulators have already released a joint statement to explain this: <https://www.nmc.org.uk/news/news-and-updates/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus/>

We are now working with the NMC to enable people to come back to work and to invite our final year student nurses and midwives to come into clinical practice to support us over the next few months.

Finally, we would like to thank you all for all the efforts you are already making. Many nursing and midwifery professionals across the NHS, public health and care services have already made major contributions to the response to COVID-19. We are very proud of the response of the professions in all areas of practice in their response to this challenge. It has been exemplary. We are confident of the commitment, dedication and hard work that nursing and midwifery professionals have and will continue to have in the very testing event of a significant epidemic in the UK.

Your professionalism and work has never been more vital or more valued.

Yours sincerely



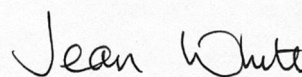
Ruth May  
Chief Nursing Officer, England



Fiona McQueen  
Chief Nursing Officer, Scotland



Charlotte McArdle  
Chief Nursing Officer, Northern Ireland



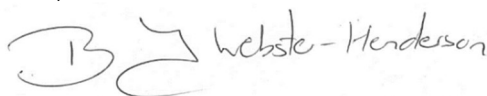
Jean White  
Chief Nursing Officer, Wales



Dame Donna Kinnair  
CEO, RCN



Andrea Sutcliffe  
Chief Executive and Registrar, NMC



Professor Brian Webster-Henderson  
Chair, Council of Deans of Health



Gill Walton  
Chief Executive, RCM



## Appendix 7: Summary of Required Establishment

<b>Health board/trust:</b>	Name: Betsi Cadwalader UHB	
<b>Period reviewed:</b>	Start Date: 01/04/2020	End Date: 31/03/2021
<b>Number of wards where section 25B applies:</b>	<b>Medical:</b>	<b>Surgical:</b>
	YG 7 YGC 8 YWM 9	YG 3 YGC 4 YWM 4

To be completed f EVERY wards where section 25B applies

\*Supernumerary i.e. 1 WTE supernumerary ward sister/charge nurse included in the establishment

### YG Medical

Ward	Required Establishment at the start of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Aran	24.07	14.48	Yes	25.58	19.13	Yes	No	No		Yes	Yes	Aran ward re purposed as a COVID ward in April 2020
Tryfan	20.98	8.75	Yes	20.98	15.03	Yes	Yes	Yes	Additional HCA's to support the increased acuity	No	No	
Glyder	14.45	7.44	Yes	12.8	8.19	Yes	Yes	Yes	Reduction of trained on a late and increase of HCA on the late	No	No	
Hebog	26.56	11.73	Yes	24.77	13.66	Yes	Yes	Yes	Increase in HCA due to acuity	No	No	
Moelwyn	24.07	13.11	Yes	31.27	16.4	Yes	No	No		Yes	Yes	Moelwyn re purposed as a non COVID resp/ agp area- additional



												RN and HCA needed April 2020
Glaslyn	17.91	23.16	Yes	19.9	21.86	Yes	Yes	No	No changes required	No	No	
Prysor	13.67	8.61	yes	12.8	8.19	yes	no	no	No changes required	no	no	

## YG Surgical

Ward	Required Establishment at the start of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Tegid	28.44	19.14	Yes	22.74	16.4	Yes	Yes	Yes	Reduction of beds resulting in a reduction of RN's and HCA's	No	No	
Ogwen	17.36	21.86	Yes	19.9	21.86	Yes	Yes	Yes	Increase in RN due to clinical acuity of patient	No	No	
Conwy	25.13	16.41	Yes	23.96	15.62	Yes	Yes	Yes	Amended function on the ward resulting in reduction of RN and HCA	No	No	

## YGC Medical

Ward	Required Establishment at the start of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
1	18.53	15.43	Yes	18.53	15.43	Yes	No	No	Out of cycle due to Covid	Yes	No	December 2020 – February 2021 repurposed due to Covid.  March 2021 Returned to S.25B ward.  Ward Manager taken out of supervisory during December 2020 to March 2021.
2	18.58	17.93	Yes	18.58	19.23	Yes	No	No	Out of cycle due to Covid	Yes	Yes	Remained as S.25B act ward during phase 2 of Covid  Additional HCSW added at review.  Additional band 6 temporarily added to support clinical nursing leadership.  Ward Manager taken out of supervisory during December 2020 to March 2021.
4	18.58	15.01	Yes	18.58	16.43	Yes	No	No	Out of cycle due to Covid	Yes	Yes	Remained as S.25B act ward during phase 2 of Covid  Additional HCSW added at review.

												<p>Additional band 6 temporarily added to support clinical nursing leadership.</p> <p>Ward Manager taken out of supervisory during December 2020 to March 2021.</p>
9 (Was ward 2, was Aberconwy was DOSA)	18.59	15.71	Yes	18.59	15.43	Yes	No	No	Out of cycle due to Covid	Yes	Yes	<p>Remained as S.25B act ward during phase 2 of Covid</p> <p>Additional HCSW added at review.</p> <p>Additional band 6 temporarily added to support clinical nursing leadership.</p> <p>Ward Manager taken out of supervisory during December 2020 to March 2021.</p>
11	24.33	10.91	Yes	24.33	13.13	Yes	No	No	Out of cycle due to Covid	Yes	Yes	<p>Remained as S.25B act ward during phase 2 of Covid</p> <p>Additional HCSW added at review.</p> <p>Additional band 6 temporarily added to support clinical nursing leadership.</p> <p>Ward Manager taken out of supervisory during December 2020 to March 2021.</p>
12	18.58	15.01	Yes	18.58	16.43	Yes	No	No	Out of cycle due to Covid	Yes	Yes	<p>Remained as S.25B act ward during phase 2 of Covid</p> <p>Additional HCSW added at review.</p>

												<p>Additional band 6 temporarily added to support clinical nursing leadership.</p> <p>Ward Manager taken out of supervisory during December 2020 to March 2021.</p>
14	24.33	10.91	Yes	24.33	12.5	Yes	No	No	Out of cycle due to Covid	Yes	Yes	<p>Remained as S.25B act ward during phase 2 of Covid</p> <p>Additional HCSW added at review.</p> <p>Additional band 6 temporarily added to support clinical nursing leadership.</p> <p>Ward Manager taken out of supervisory during December 2020 to March 2021.</p>
DOSA (Was ward 9)	18.85	14.45		18.85	16.45	Yes	No	No	Out of cycle due to Covid	Yes	Yes	<p>Repurposed as Acute CPAP Covid ward from 24.12.2020 to 8.3.2021</p> <p>Additional band 6 added to support clinical leadership.</p> <p>8.3.21 Returned to section 25B act ward.</p> <p>Ward Manager taken out of supervisory during December 2020 to March 2021.</p>

## YGC Surgical

Ward	Required Establishment at the start of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 3	19.81	10.54	Yes	18.06	11	Yes	No	No	Reviews out of cycle due to COVID.	No	No	Ward remains an S.25B Adult Surgical Ward. Uplift in HCSW recommended following establishment review March 2020. Additional Band 6 to support nursing leadership. Ward Manager taken out of supervisory during December 2020 to March 2021.
Ward 5	24.33	16.49	Yes	24.33	15.49	Yes	No	No	Reviews out of cycle due to COVID.	Yes	No	Ward remains an S.25B Adult Surgical Ward. Review deferred due to COVID and completed May 2020. Ward Manager taken out of supervisory during December 2020 to March 2021.
Ward 7	24.07	22.92	Yes	24.07	20.12	Yes	No	No	Reviews out of cycle due to COVID.	Yes	No	Ward remains an S.25B Adult Surgical Ward. Review deferred due to COVID and completed May 2020. Ward Manager taken out of supervisory during December 2020 to March 2021.

Ward 8	18.53	15.01	Yes	18.53	16.43	Yes	No	No	Reviews out of cycle due to COVID.	Yes	Yes	Ward remains an S.25B Adult Surgical Ward Review deferred due to COVID and completed May 2020 Additional HCSW added following review. Ward Manager taken out of supervisory during December 2020 to March 2021.
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# YWM Medical

Ward	Required Establishment at the start of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Morris	16.35	18.55	Yes	16.35	18.55	Yes	In part	No		No	No	Remained as original function, S.25B act ward during phase 2 of Covid  Ward Manager taken out of supervisory during December 2020 to March 2021 to support surge staffing.
Mason	18.91	14.76	Yes	18.91	14.76	Yes	In part	Yes	January calculation deferred due to COVID-19	No	No	Currently based on Erddig Ward template due to COVID 19 infrastructure response. . No changes required due to acuity & dependency of patients  Remained as S.25B act ward during phase 2 of Covid  Ward Manager taken out of supervisory during December 2020 to March 2021 to support surge staffing.
Evington	15.18	12.63	Yes	15.18	12.30	Yes	In part	Yes	January calculation deferred due to COVID-19	No	No	Currently based on POW template due to COVID 19 infrastructure response Repurposed to COVID 19 cohort ward October 2020.  Ward Manager taken out of supervisory during December 2020 to March 2021 to support surge staffing.
Erddig	24.02	12.4	Yes	24.02	16.09	Yes	In part	Yes	January calculation deferred due to COVID-19	No	No	Ward based on Acton template to deliver high care respiratory

Ward	Required Establishment at the start of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
												care during COVID 19 response. Repurposed to COVID 19 cohort ward April 2020. Ward Manager taken out of supervisory during December 2020 to March 2021 to support surge staffing
Cunliffe	18.91	12.3	Yes	18.91	12.3	Yes	In part	No	January calculation deferred due to COVID-19	No	No	Remained as original function, S.25B act ward during phase 2 of Covid  Ward Manager taken out of supervisory during December 2020 to March 2021 to support surge staffing.
Bromfield	10.23	4.92	Yes	10.23	4.92	Yes	In part	NA	January calculation deferred due to COVID-19	Yes	Yes	Bromfield relocated to Bonney template to support COVID 19 response as a COVID cohort ward March 2020. Additional staff calculated to be required for this template but budget not adjusted.  Ward Manager taken out of supervisory during December 2020 to March 2021 to support surge staffing
Bersham	24.02	12.30	Yes	24.02	12.30	Yes	In part	Yes	January calculation deferred due to COVID-19	No	No	Remained as original function, S.25B act ward during phase 2 of Covid  Ward Manager taken out of supervisory during December 2020 to March 2021 to support surge staffing.
ACU	29.14	12.30	Yes	29.14	12.30	Yes	In part	Yes	January calculation deferred due to COVID-19	No	No	Remained as original function, S.25B act ward during phase 2



Ward	Required Establishment at the start of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Bonney COVID-19	22.74	16.4	Yes			Yes	In part	NA	January calculation deferred due to COVID-19	Yes	Yes	<p>Establishment calculated for template to operate as a COVID 19 ward but not funded.</p> <p>Ward Manager taken out of supervisory during December 2020 to March 2021 to support surge staffing</p>

## YWM Surgical

Ward	Required Establishment at the start of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Fleming ward	29.43	17.40	Yes	29.43	17.40	Yes	In part	Yes	January calculation deferred due to COVID-19	No	No	Remained as original function, S.25B act ward during phase 2 of Covid  Ward Manager taken out of supervisory during December 2020 to March 2021 to support surge staffing.
ENT ward	15.21	11.93	Yes	15.21	11.93	Yes	In part	Yes	January calculation deferred due to COVID-19	NA	No	Repurposed to COVID 19 cohort ward December 2020 – March 2021.  Ward Manager taken out of supervisory during December 2020 to March 2021 to support surge staffing
Pantomime ward 29 funded	23.74	21.13	Yes	23.74	21.13	Yes	In part	Yes	January calculation deferred due to COVID-19	No	No	Currently based on Mason template as part of infrastructure response to COVID 19  Remained as original function, S.25B act ward during phase 2 of Covid

Ward	Required Establishment at the start of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Prince of Wales ward	15.21	11.93	Yes	15.21	11.93	Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	<p>Ward Manager taken out of supervisory during December 2020 to March 2021 to support surge staffing.</p> <p>Currently based on pantomime template and support COVID 19 response. Additional support staff required to support dependency of patients but no additional permanent allocation of budget.</p> <p>Repurposed to COVID 19 cohort ward January 2021 – March 2021. Ward Manager taken out of supervisory during December 2020 to March 2021 to support surge</p>



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Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

## **Chair's Report**

### **Alert Assurance Achievement (AAA)**

<b>Reporting Group</b>	
<b>Name of meeting</b>	Patient Safety and Quality Group
<b>Chair of meeting</b>	Gill Harris Executive Director of Nursing and Midwifery/Deputy CEO
<b>Date of meeting</b>	13 April 2021
<b>Version number</b>	1
<b>List Appendices, if applicable</b>	None

<b>Reporting To</b>	
<b>Name of meeting</b>	Quality, Safety & Experience (QSE) Committee
<b>Date of meeting</b>	4 <sup>th</sup> May 2021
<b>Presented by</b>	Gill Harris Executive Director of Nursing and Midwifery/Deputy CEO

#### **1. Alert – include all critical issues and issues for escalation**

There are no matters for formal escalation for the Committee to act upon.

The Group noted the work of the Safe Clean Care campaign that has been re-launched. The Executive Director of Nursing and Midwifery advised that the Infection Prevention Control (IPC) Group may be re-aligned to report direct into the QSE Committee.

#### **2. Assurance – include a summary of all activity of the group for assurance**

A report was received regarding complaints related to communication. The group referred these matters for in-depth review to the Patient and Carer Experience Group which is due to receive reports from services on work being done to address this at its April 2021 meeting. It was noted that Wrexham Maelor Hospital was to pilot a Matron Helpline and a presentation will be received at a future meeting.

A Chair's Report from the Infection Prevention and Control Group was received. This report covered:

- The infection prevention performance position shows we are not an outlier compared to other health boards.
- The Board Assurance Framework risk as scrutinised and reviewed prior to submission to the Board.
- As outlined above, an update was received on the Safe Clean Care Campaign.

A Chair's Report from the Personal Protective Equipment (PPE) Group was received. There are no issues to escalate and the supply chain is reported as stable. The meeting frequency of the group is being adjusted.

A Chair's Report from the Safer Medications Group was received. This report covered:

- An update on the methotrexate never event – the final report is to be finalised.
- The Controlled Drugs Accountable Officer received the independent controlled drugs review completed in October 2020 at Wrexham Maelor Hospital. The full report was presented to the Patient Safety & Quality Group (PSQG) and an action plan response was requested for the next meeting.
- Medication incidents involving insulin were identified as a theme by the medicines management nurse at Ysbyty Glan Clwyd (YGC) in September 2020 and subsequently an action plan was developed to address the identified issues.
- An Independent Prescribing Study Day was held by the medicines management nurses in February. The next study day is planned for August 16th 2021.

A Chair's Report from the Falls Group was received. This report covered:

- The Strategic Inpatient Falls Group has been re-established with the inaugural meeting being held on 25th February 2021 and a further meeting on 25th March 2021.
- The Strategic Community Falls Prevention Group has also held an inaugural meeting.
- The National Clinical Lead for Falls and Frailty is setting up an All Wales Inpatient Falls Network.
- The National Audit of Inpatient Falls is currently being undertaken and completed. The Health Board has been granted an extension until 6th April 2021.
- A BCU Standard Root Cause Analysis (RCA) Tool has been established incorporating current practice from across the Health Board.

A Chair's Report from the Quality Systems Group was received. There are no issues to escalate.

A Chair's Report from the Inpatient Nutrition Group was received. There are no issues to escalate. Compliance against the National Patient Safety Alert relating to the passing of Nasogastric (NG) tubes was noted.

Divisional reports were received and updates provided on key risks and issues. Of note from these:

- Overdue serious incidents and complaints remain a concern in most services. The Executive Director of Nursing and Midwifery set out clear expectations for this to be addressed and advised a letter will be issued shortly to services.
- In West Area, several falls with harm have found that Baywatch principle is not adhered to at the time of the fall. Lessons learnt from Serious Incident Reviews (SIRs) have

been cascaded within teams. A Plan Do Study Act (PDSA) is in place to strengthen the Baywatch system and outcomes will be shared at the next PSQG

- In East Area, a deep-dive of falls in March 2021 was completed. Primary focus on Chirk Community Hospital and Rehab Unit due to increase number of inpatient falls with a number of incidents of harm. Initial review identified that staff complete a reactive approach to falls mitigation rather than a proactive approach. Engagement is underway with the with falls collaborative team, transforming care and clinical specialists. Linked were made to the potential learning from the PDSA in West is being explored following the meeting
- In Central Area, there remains a reduction in General Anaesthesia (GA) services across BCU which is impacting service delivery and waiting lists for Community Dental Services. In NWAS, there has been a loss of additional qualified staff taking the numbers down to approx. 53% qualified staff from mid-April.
- In Mental Health and Learning Disabilities (MHL), since March 2020 the North Wales Community Health Council (NWCHC) have been undertaking public engagement and formal consultation exercises across North Wales focusing on broad themes of mental health services in North Wales. The Division has accepted in full the 9 recommendations identified within the review. This will be presented at QSE Committee.

The bi-monthly Quality Assurance Report was receive which included details on Healthcare Inspectorate Wales (HIW) activity. A separate report is provided to the QSE Committee with more detail.

A report was received on the development of a Quality Assurance Framework (QAF) is a key priority for the Corporate Care Home Team to ensure the delivery of standardised high quality care in our commissioned services. A draft framework is under development and starts from a number of key principles.

A report was received on the first annual patient safety culture survey. Due to time and technical constraints the presentation was not able to be received and will be presented at the next meeting.

### **3. Achievement – include any significant achievements and outcomes**

A number of achievements are noted in the above sections – in particular the first patient safety culture survey, the progress of the HIW maternity action plan and the Safe Clean Care campaign.

The meeting was observed by Audit Wales as part of their quality governance review.



## Antimicrobial Prescribing Policy

**MM10**

Date to be reviewed:	Xxx (3 years from approval)	No of pages:	14		
Author(s):	Antimicrobial Pharmacist / BCU Antimicrobial Steering Group (ASG)				
Responsible dept / director:	Executive Medical Director				
Approved by:	Quality, Safety & Experience Committee: 00/00/21				
Date approved:	MPPP 22/01/20 DTG 05/02/20 QSG: 18/02/20				
Date activated (live):	xxx				
Date EQIA completed:	Reviewed January 2021				
Documents to be read alongside this policy:	Microguide® AWMSG All-Wales Primary Care Antimicrobial Guidelines BCUHB Medicines Policy MM01 BCUHB Injectable medicines policy MM02 BCUHB Restricted Antimicrobial Policy MM34 BCUHB Outpatient Parenteral Antimicrobial Therapy (OPAT) Overarching Guideline 2020 Together for Health Tackling antimicrobial resistance and improving antibiotic prescribing: A Delivery Plan for NHS Wales and its partners 2016 Tackling antimicrobial resistance 2019 to 2024: the UK's 5 year national action plan Department of Health 2019 Contained and Controlled: The UK's 20-year vision for antimicrobial resistance Department of Health 2019				
Purpose of Issue/Description of current changes: Policy produced to comply with Health and Social Care Act (2008) and Welsh Code of Practice for the Prevention and Control of Healthcare Associated Infections (2014)					
First operational:	13/12/2013				
Previously reviewed:	8/6/16	25/5/17	14/11/19	21/01/2020	
Changes made yes/no:	Yes	yes	yes	yes	

PROPRIETARY  
INFORMATION

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## 1. Executive Summary

Antibiotics may be lifesaving in severe infections. In order to preserve their usefulness, the judicious use of antimicrobials and good antimicrobial stewardship must be an integral part of everyday practice and is a priority for **all** clinical personnel. This will help to reduce the development of antibiotic resistance and to reduce the risks of complications associated with antibiotics such as *Clostridium difficile* infection.

Antibiotics should **not be** started unless there is clear evidence of bacterial infection and a likely benefit to treatment.

Initiating antibiotic should always involve antibiotic stewardship. All prescriptions should be for the shortest course possible and with a clear indication following Microguide® when appropriate. Secondary care **must** involve all Antibiotic Review Kit (ARK) principles:

### Initial Prescription:

- Prompt (within one hour of diagnosis) antimicrobial prescribing and administration in patients with severe sepsis or life-threatening infections.
- Thorough plan to investigate for source of infection where infection is suspected but source is initially unclear.
- Obtain appropriate samples for culture where to do so will not unduly delay therapy
- A thorough drug allergy history including name of drug and nature of the allergy.
- Consideration of patient history including recent antibiotics, past history of resistant organisms and previous *Clostridium difficile* infection.
- Classification of the initial prescription should acknowledge what diagnostic uncertainty exists by assigning one of two categories: **Probable** or **Possible** infection.
- Initial prescription must be prescribed on the initial prescription section of the ARK inpatient medication administration record.
- Consult with Microguide® for appropriate antibiotic choice and guidance. If information available is insufficient, consult with microbiology or an antimicrobial pharmacist for further advice.
- For **all** antibiotics including long term prophylaxis and surgical prophylaxis document indication and severity (where appropriate), drug, dose, route and rationale for choice on medication chart **and** in the medical record. Antibiotics commenced pre- admission should be assessed and where deemed appropriate to continue, documentation should support this assessment.
- Document review or stop date or duration on the medication chart and in the medical record.
- When surgical prophylaxis is indicated, prescribe single dose prophylaxis unless directed otherwise in Microguide®.

### **Review and revise:**

- All initial prescriptions 24-72 hours after starting must be reviewed and revised as per the ARK principles. If there is a failure to 'Review & Revise', this will lead to the antimicrobial course automatically stopping at 72 hours.
- The review and revise decision aid tool must be completed on the medication chart and documented with the outcome either as:
  - Stop
  - Continue with one of the following actions:
    - IV to oral switch
    - Change antimicrobial
    - Continue same antimicrobial
    - Outpatient Parenteral Antimicrobial Therapy.
- Signed and dated on the medicines chart and recorded in the medical notes

### **Finalised prescription**

- Once the above decision is made for antimicrobials to continue, a finalised prescription must be written.
- A finalised diagnosis may be microbiologically proven or may be a clinically finalised diagnosis without specific microbiology.

## **2. Introduction and Policy Statement**

The Health and Social Care Act 2008 Criterion 9 “*Code of Practice on the prevention and control of infections and related guidance*” applies to all providers of healthcare and adult social care. Registered care providers must comply with requirements for infection control, including antimicrobial stewardship. These requirements are further explained for organisations within Wales in the Welsh Code of Practice for the Prevention and Control of Healthcare Associated Infections. This policy complies with the tasks set out in the Together for Health Tackling antimicrobial resistance and improving antibiotic prescribing: A Delivery Plan for NHS Wales and its partners 2016 which is the policy set out by Welsh Government to tackle Antimicrobial Resistance.

The Health Board is required to have procedures in place to ensure prudent prescribing and antimicrobial stewardship as well as an ongoing programme of audit, revision and update.

Antimicrobials may be life-saving, but their use, whether appropriate or inappropriate, selects for antimicrobial resistance. An antimicrobial stewardship programme is a key component in the reduction of healthcare associated infections (HCAI) and contributes to slowing the development of antimicrobial resistance.

Betsi Cadwaladr University Health Board (BCUHB) is committed to promoting prudent use of antimicrobials in order to reduce the development of antibiotic resistance and to reduce the risks of complication associated with antibiotics such as *Clostridium difficile* infection. This is a priority for **all** clinical personnel and must be an integral part of everyday practice.

### 3. Purpose of the Document

This policy forms part of BCUHB's quality improvement strategy for patient safety, providing a framework for staff to follow to help reduce inappropriate prescribing and optimise antibiotic use. The policy will be available via the BCUHB intranet and via the Microguide<sup>®</sup> app.

### 4. Scope

The policy specifies the roles and responsibilities of healthcare personnel in ensuring that antimicrobial prescriptions are appropriate and regularly reviewed. Any deviations from this policy must be evidenced by adequate documentation within the medical notes stating the reason for deviation and justifying actions taken.

### 5. Aims and Objectives

The aim of this policy is to support evidence-base best practice, limiting unnecessary use or overly prolonged courses of antimicrobials and reducing the development of antibiotic resistance and adverse effects of antibiotics including healthcare associated infections such as *C. difficile* infection. The Start Smart then Focus (SStF) approach is recommended by the Department of Health and supported by Public Health Wales. The ARK stewardship process is also supported throughout NHS Trusts and Health Boards in the United Kingdom.

### 6. Roles and Responsibilities

#### 6.1 Antimicrobial Prescribing

Antimicrobials should **not** be started unless there is clear evidence of bacterial infection and a likely benefit to treatment

#### Allergy status

Allergy status including name of drug and nature of the allergy, wherever possible, must be ascertained and documented prior to prescribing and the administration of any antimicrobial. First line empiric therapy will provide best coverage for any given infection and should be used wherever possible, particularly if previous reactions are non-severe and not allergic in nature. The alternative choice may not be as potent against likely pathogens, may be more toxic and may carry increased risk of the patient developing *Clostridium difficile* and resistant organisms. If amendments are made to allergy status during hospital admission, there should be adequate communication to the patient and other healthcare professionals of these changes.

#### Recent history

Antibiotic use, previous history of resistant organisms and previous *Clostridium difficile* infection should all be considered when considering choice of antimicrobial. These factors may influence first-line therapy and may be justified reasons to deviate

from the recommendations outlined in Microguide®. If in doubt, microbiology should be contacted for advice and there should always be documented evidence in the medical record of any deviation from standard practice.

### **Antimicrobial choice**

Consult Microguide® for appropriate antimicrobial choice and guidance. If information available is insufficient, consult with microbiology or an antimicrobial pharmacist for further advice. All antimicrobial prescribing must adhere to the BCUHB restricted antimicrobial policy and be prescribed according to this policy.

Drug interactions and contraindications should be checked using the most up to date British National Formulary or the British National Formulary for children. Altered drug handling due to pregnancy, breast-feeding, organ dysfunction, body weight etc. may require dosage adjustment or alternative antimicrobials. Advice can be obtained from Pharmacy if necessary.

### **Cultures and sensitivity**

Obtain cultures as soon as possible and ideally before administering any antimicrobial therapy. In patients demonstrating systemic inflammatory response or with suspected meningitis, administration of antibiotics **should never be unduly delayed** whilst obtaining cultures.

In patients who are not septic, it may be prudent to wait for the results of cultures so that treatment can be targeted from the start but the patient should be regularly monitored for signs of deterioration.

### **Duration**

For the majority of infections, the duration should be as short as possible to balance effective treatment against a generation of resistance. Guidance on course lengths has been included in Microguide® wherever possible.

## **6.1.1 Inpatient prescribing (adults)**

### **Sepsis – initial prescription**

First dose antimicrobials should be prescribed as a “stat” on the front of the medication chart, indicating the time when the drug is to be administered. It is the prescriber’s responsibility to communicate verbally with the nurse caring for patient to ensure this dose is given or to administer the dose directly.

**Start Smart within one hour**

### **Prompt (within one hour of diagnosis) initiation of antibiotics in severe sepsis**

Patients with signs and symptoms of severe sepsis require urgent management according to the Sepsis Six care bundle.

**Use of the Sepsis Six care bundle should be accompanied by an assessment of likely infection source and review of Microguide® to ensure that recommended agents provide adequate antimicrobial cover.**

## Antibiotic Review Kit (ARK) tool

BCUHB has adopted the ARK tool as its method of stewardship in secondary care. All healthcare staff are to complete the eLearning associated with the ARK tool to understand the stewardship methods being used in BCUHB.

## Initial Prescription

All initial acute antibiotic prescriptions, following the initial stat dose must be prescribed on the initial prescription section part of the medicines chart. This section of the chart must be completed in full. The initial antibiotic must be categorised as either **probable** or **possible**. The initial prescription is for a maximum of 72 hours.

**All initial antibiotic prescriptions must be reviewed by 72 hours of their initiation.**

After 72 hours the prescription will automatically stop. Without any action the patient will receive no further doses. **It is the responsibility of the consultant and their team who are caring for the patient to ensure this review happens.** Other ward teams, such as nursing and pharmacy should raise and encourage the review process with the responsible consultant team, especially if the 72 hour stop is imminent.

## 24-72 Hour review and revise

The review of the initial prescription at up to 72 hours must be documented both on the medication chart using the decision aid tool and also in the medical notes.

The review must include the final clinical diagnosis, microbiology results, radiology and other tests to decide the continuing need for any antimicrobial. At the time of review, document a clear plan of action in the medical notes detailing one of the following decisions:

One of the following actions should be taken and documented accordingly;

- STOP if no longer necessary
- Continue (review any Culture and sensitivities)
  - IV to oral switch
    - Switch IV to Oral therapy. This should be based on culture and sensitivity results where possible or on the recommended step-down regimes detailed in Microguide® where culture results are unavailable (See appendix 1 for switching criteria).
  - Change antimicrobial
    - To a targeted narrower spectrum therapy based on culture and sensitivity results.
    - Or
    - Step up treatment depending on infection severity if the patient is not responding. Senior clinicians should discuss the patient with a consultant microbiologist or antimicrobial pharmacist. In treatment failure after prolonged courses, it may be appropriate to stop all antimicrobials and reassess the case.
  - Continue same antimicrobial
  - Outpatient Parenteral Antimicrobial therapy (OPAT) discuss with the relevant teams to arrange this

If IV antimicrobials are deemed necessary and likely to be required for 7 days or more, consideration should be given to the insertion of a Peripherally Inserted Central Catheter (PICC) line or any other catheter devices so that cannula replacement is not necessary.

An example of an initial prescription

PATIENT'S NAME A. Patient HEALTH RECORD NUMBER Ap 32123  
MORNING (around 08:00); MIDDAY (between 12:00 & 14:00); EVENING (around 18:00); BEDTIME (around 22:00)

**INITIAL ANTIMICROBIAL PRESCRIBING SECTION** (For surgical prophylaxis, use the once only section on the front of the chart)  
Long-term prophylaxis should be prescribed in the appropriate section on page 4  
Review need for all Proton Pump Inhibitors/ H2 antagonists (increased C. difficile risk) – discontinue if appropriate  
PROBABLE = Infection is the most likely diagnosis so antimicrobial prescribed as a provisional prescription but diagnosis and treatment still need to be reviewed  
POSSIBLE = Infection is NOT the most likely diagnosis but antimicrobial prescribed as patient unstable/clinical concern pending further information and review

INITIAL PRESCRIPTION		Antimicrobial – Initial Prescription		Category of Initial Prescription (Circle)		PRESCRIBER'S SIGNATURE		PHARMACIST		Discharge Prescription		
Check for allergies		Flucloxacillin		PROBABLE POSSIBLE		A. Doch...						
DATE →	10/12/19	Indication/diagnosis		Rationale for Choice (circle)		Bleep No.		SUPPLY		TOTAL duration		
ROUTE →	IV	Cellulitis		Guidelines Micro advice/C&S		12345						
SPECIFY TIME IF REQUIRED ↓	DOSE ↓	SIGN ↓	DATE	11/12	12/12	<b>Prescription will stop here unless reviewed and re-prescribed if necessary</b> <b>24-72 hour Review and Revise:</b> <b>STOP</b> <input type="checkbox"/> <b>CONTINUE (review any C&amp;S):</b> IV to oral switch <input checked="" type="checkbox"/> Change antimicrobial <input type="checkbox"/> Continue same antimicrobial <input type="checkbox"/> Outpatient Parenteral Antimicrobial therapy <input type="checkbox"/> Signature and bleep: <u>AD. 12345</u>						
			DAY 1	2	3							4
Morning	6am 2g											
Midday	12pm 2g											
Evening	6pm 2g											
Bedtime	10pm 2g						<b>NURSES:</b> Administration must follow the date line provided for EACH separate prescription If prescription is ending and review section not completed contact team for urgent review Special Instructions Final Prescription pg. 3 or 4					

### Finalised prescription

Once the review and revise has been completed the antimicrobial will be stopped the finalised prescription should be completed

An example of a finalised prescription



PATIENT'S NAME A. Patient HEALTH RECORD NUMBER Ab32123

MORNING (around 08:00); MIDDAY (between 12:00 & 14:00); EVENING (around 18:00); BEDTIME (around 22:00)

**FINALISED ACUTE ANTIMICROBIAL PRESCRIBING SECTION** (For surgical prophylaxis, use the once only section on the front of the chart)

Long-term prophylaxis should be prescribed in the appropriate section on page 4

Review need for all Proton Pump Inhibitors/ H2 antagonists (increased C. difficile risk) – discontinue if appropriate

FINALISED PRESCRIPTION = After observation, review of cultures and investigation and senior (ST3+) / specialist input a final choice of antimicrobial, route and duration is made

Check for allergies		Antimicrobial – Finalised Prescription		Duration OR review date:		PRESCRIBER'S SIGNATURE	PHARMACIST	Discharge Prescription
		Flucloxacillin		5 days total		A. Doch		
DATE →	13/12/19	Indication		Rationale for Choice (circle)		Bleep No.	SUPPLY	TOTAL duration
ROUTE →	po	cellulitis		Guidelines/ Micro advice/C&S		12345		
SPECIFY TIME IF REQUIRED ↓	DOSE ↓	SIGN	DATE	DAY		Administration must follow the date line provided for EACH separate prescription		
			13/12	14/12		<p><b>Prescription will stop here unless you prescribe again</b></p> <p>Special Instructions</p>		
			4	5				
Morning	6am 500mg							
Midday	12pm 500mg							
Evening	6pm 500mg							
Bedtime	10pm 500mg							

## Antibiotics for Medical Prophylaxis

If treatment antibiotics have been started, long term prophylaxis should be reviewed. It may be appropriate to withhold prophylaxis until treatment is complete if the antibiotics cover the same antimicrobial spectrum.

If the patient has had breakthrough infections despite being on prophylaxis or there is evidence to suggest the development of antimicrobial resistance, a decision should be taken regarding the risks and benefits of continuing prophylaxis. Do not issue repeat prescriptions for antimicrobials unless needed for a particular clinical condition or indication. Avoid issuing repeat prescriptions for longer than 6 months without review and ensure adequate monitoring for individual patients to reduce adverse drug reactions and to check whether continuing an antimicrobial is really needed.

### 6.1.2 Paediatric and Intensive Care prescribing

Prescribing in paediatrics and on intensive care settings must follow the start smart then focus principles. Prescribing in these areas is on separate tailored medicines chart and these both have antimicrobial sections where all information on the antimicrobial must be documented in full.

### 6.1.3 Outpatient and primary care prescribing

All prescriptions in both outpatients setting and in all primary care settings should follow Microguide® for empirical prescribing choices and tailored choices should follow culture and sensitivities and/or consultant microbiology advice.

All prescriptions should follow the good prescribing practice and have a clear indication recorded in the patient's notes, correct dose, frequency and a clear duration. Patients should have clear information on their prescription.

## **6.2 Actions for Staff involved in the Administration and Monitoring/Review of Antibiotics (Nursing staff, pharmacists and pharmacy technicians)**

Check allergy status prior to every administration or prescription review.

Ensure all antimicrobial prescriptions have a documented indication and a stop or review date.

Alert the medical team if the ARK category (Possible or Probable) has not been assigned when **starting** initial antibiotic prescriptions.

Check all doses are prescribed with times for administration which are evenly spaced through the 24 hour period.

Ensure the administration of all prescribed antimicrobials at the times prescribed.

Query every prescription continuing beyond a review or stop date with the responsible prescriber. Nursing staff should continue to administer doses until directed otherwise.

Be alert for omitted or overly delayed antimicrobial doses. The responsible team should be alerted immediately in order that the patient can be reviewed for evidence of sepsis. Antimicrobials are critical medicines and omissions should be reported via Datix®.

Be alert for the loss of access (intravenous, oral). The responsible team should be alerted immediately if a patient cannot receive prescribed antimicrobials for any reason.

In cases where the prescriber cannot be contacted to ensure the above in a timely manner, escalate up to the clinical team until such information is forthcoming. Report any difficulties encountered to the Ward Manager or Matron for further escalation to the appropriate Clinical Director if there is any further delay in the prescription being clarified.

For initial prescription using the ARK chart alert the prescriber to complete the review and that the prescription is due to end, before the final dose is given.

## **6.3 Actions for Infection Prevention and Control Doctor**

The infection prevention and control doctor, and other consultant microbiologists have the authority to challenge inappropriate practice and inappropriate prescribing decisions. Repeated, unjustified non-compliance should be reported to them. They will liaise with relevant medical staff to escalate and address any persistent unjustified non-compliance and escalated as appropriate to the relevant line manager or clinical lead. See appendix 2 of the escalation pathway for prescribing.



## **7. Monitoring, Escalation and Implementation Arrangements**

Global monitoring is undertaken by the Antimicrobial Steering Group via the annual All Wales Antimicrobial Point Prevalence Survey, consumption data and other local audits. These are reviewed by the Strategic Infection Prevention Group.

Each health division (east, central and west) is responsible for auditing their own adherence to this policy, taking advice from the Antimicrobial Steering Group where necessary. The audit tool to audit antimicrobial prescribing will be available for use throughout secondary care and audit arrangements as per the local enhanced services for primary care.

Each health economy is expected to report via the Local Infection Prevention and Decontamination Groups and the local Antimicrobial Steering Group (ASG) its compliance with the standards contained in this Policy. This should be done using the approved method

Each health economy should also report their adherence to the attendance of their junior doctors at antimicrobial prescribing training sessions as outlined in the Education and Training Strategy. Poor attendance should result in a request to the relevant Antimicrobial Pharmacist for a further session.

Formal investigation of prescribing may be undertaken in cases of repeated unjustified non-compliance by particular clinical teams. Repeated non-compliance does not have to result in adverse patient outcomes before investigation is undertaken.

Each health division should also nominate one BCU-wide representative to assist with guideline and practice development by the Antimicrobial Steering Group. This individual must be in a position to consult medical, surgical and nursing colleagues across their health economy and collate a single health economy response to any proposed draft guidance.

## **8. Reference to Legislation**

This policy complies with The Health and Social Care Act 2008 Criterion 9 “*Code of Practice on the prevention and control of infections and related guidance*” as well as Department of Health recommendations concerning antimicrobial stewardship and the Welsh Code of Practice for the Prevention and Control of Healthcare Associated Infections.

## References

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2. BCU Antimicrobial Stewardship Committee. (2020) Surgical and Procedural Prophylaxis Guidelines. BCUHB Surgical and Procedural Antibiotic Prophylaxis Guidelines.
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5. Public Health England (2015) Start Smart Then Focus: Antimicrobial Stewardship Toolkit for English Hospitals, London: Public Health England.
6. Scottish Antimicrobial Prescribing Group. (2013) Good Practice Recommendations for Antimicrobial Use in Frail Elderly Patients in NHS Scotland. Edinburgh: Scottish Medicines Consortium.
7. NICE Clinical Guideline 183. Drug allergy: diagnosis and management of drug allergy in adults, children and young people. <http://www.nice.org.uk/guidance/cg183>.
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9. Antimicrobial Stewardship: Systems and Processes for effective antimicrobial medicine. NICE August 2015. Accessed May 2016.
10. ARK toolkit Available at: <http://www.arkstudy.ox.ac.uk/>. Accessed October 2019.
11. Tackling antimicrobial resistance 2019 to 2024: the UK's 5-year national action plan Department of Health and Social Care. Published 24 January 2019.
12. Contained and controlled: the UK's 20-year vision for antimicrobial resistance How the UK will contribute to containing and controlling antimicrobial resistance (AMR) by 2040. Department of Health and Social Care. Published 24 January 2019.

## 10 Appendices

### 10.1 Intravenous to Oral switch criteria

#### Initial Indications for Intravenous Antimicrobials

Hospitalisation due to infection is not an automatic indication for intravenous antimicrobial. Oral treatment is appropriate in the majority of cases. Patients with any of the following characteristics should be considered for intravenous antimicrobials:

- Systemic Inflammatory Response Syndrome or Sepsis Severe Sepsis
- National Early Warning Score (NEWS)  $\geq 6$
- Specific indications for antimicrobials as per BCUHB Microguide®
- Enteral absorption cannot be guaranteed
  - Vomiting
  - Absorbing below 30mL/hour enterally
  - Nil by mouth
  - Unsafe swallow
  - Patient refusing oral medication

In these cases, IV antimicrobials are lifesaving but they may be changed to enteral when the patient's condition allows and after senior consultation.

#### Intravenous to Oral Switching

Intravenous antimicrobials are recommended throughout the course in bacterial meningitis, osteomyelitis, septic arthritis, bacterial endocarditis, neutropenic sepsis and some cellulitis patients.

Any advice given by microbiology should be documented clearly in the notes.

Patients must meet the following criteria before a route switch can be considered.

- Clinical improvement
- Oral fluids tolerated ( $>30\text{mL/hour}$  intake)
- No vomiting, diarrhoea (if not regular bowel habit) or evidence of absorption difficulties

**Patients with enteral tubes:** Enteral feeding tubes are an unlicensed method of administration. If antimicrobials are to be switched from IV to this route, this must be done in consultation with senior medical staff. Where IV to enteral **liquid** preparations are required for example for patients with enteral tubes, pharmacy should be contacted for advice. In some cases it may be prudent to continue the antibiotic via the IV route. Products become unlicensed when given by a different route than those specified in product license. Interactions may occur with enteral feeds (e.g. ciprofloxacin and doxycycline) which may render the antibiotic ineffective.

Patients no longer meeting the criteria for sepsis or severe sepsis (see sepsis policy) should have their antimicrobials changed to the enteral route. The following factors may also be considered when making route switches.

- C-reactive protein (CRP) reducing from when parenteral therapy started
- Microbiology culture and sensitivities available

If culture and sensitivity results are not available and all other criteria are met, the patient should be discussed with senior members of the clinical team and a decision made on further therapy.

If IV therapy is continued beyond 48-72 hours from initiation, it should be further reviewed on a daily basis and stepped down when possible. **Preferred oral step down agents** are indicated by indication as per Microguide<sup>®</sup>. These are to be used in conjunction with culture and sensitivity results on an individual patient basis. If use of a preferred agent is not possible, the patient should be discussed with senior members of the clinical team. In addition advice may be taken from Microbiology. Any deviances from agents specified in Microguide<sup>®</sup> should be documented clearly in the patient's clinical notes.

As a rough guide, if the agent given IV is available in enteral form, this should be used for continuing enteral treatment.

The BNF should be consulted as change from IV to oral may necessitate a dose change. Oral preparation doses may also vary depending on whether the patient needs tablet form or liquid.



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IT FORMS

**PARTS A (Screening – Forms 1-4) and**  
**B (Key Findings and Actions – Form 5)**

<u>For:</u>	Antimicrobial Prescribing Policy MM10
<u>Date form completed:</u>	27/11/20, Reviewed January 2021



**PARTS A: SCREENING and B:**

**KEY FINDINGS AND ACTIONS**

**Introduction:**

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "...all the ways in which an organisation carries out its business" so can include any or all of the above.

**Assessing Impact**

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or an impairment as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

# Part A

## Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Antimicrobial Prescribing Policy MM10
2.	Provide a brief description, including the aims and objectives of what you are assessing.	<p>The major change to the antimicrobial prescribing policy is to include the Antimicrobial Resistance Toolkit (ARK) principles now being adopted throughout the acute sites in BCUHB, and ensuring good antimicrobial stewardship.</p> <p>The aim of this policy is to support evidence-base best practice, limiting unnecessary use or overly prolonged courses of antimicrobials and reducing the development of antibiotic resistance and adverse effects of antibiotics including healthcare associated infections such as C. difficile infection. The Start Smart then Focus (SStF) approach is recommended by the Department of Health and supported by Public Health Wales. The ARK stewardship process is also supported throughout NHS Trusts and Health Boards in the United Kingdom.</p>
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	As per Policy on Policies, final approval at QSE Committee.
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	BCU Medicines Policy MM01 BCU Injectable Medicines Policy MM02

# Part A

## Form 1: Preparation

Please answer all questions

5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Prescribers and all other healthcare staff who prescribe, administer and dispense antimicrobials.
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	Communication of Policy changes to all key stakeholders
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	Antibiotics may be lifesaving in severe infections. In order to preserve their usefulness, the judicious use of antimicrobials and good antimicrobial stewardship must be an integral part of everyday practice and is a priority for all clinical personnel. This will help to reduce the development of antibiotic resistance and to reduce the risks of complications associated with antibiotics such as Clostridium difficile infection for all patients. The World Health Organization (WHO) has declared that <a href="#">Antimicrobial resistance (AMR)</a> is one of the top 10 global public health threats facing humanity.



# Part A

## Form 2: Record of potential Impacts - protected characteristics and other groups

### Please answer all questions

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

**Remember to ask yourself this:** If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? For example, will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

# Part A

## Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Protected characteristic or group	<p>Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)</p> <p><i>for further direction on how to complete this section please click <a href="#">here training vid p13-18</a></i></p>	<p>Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: <a href="#">"Is Wales Fairer (2018)?"</a></p> <p>You can also visit their website <a href="#">here</a></p>	<p>How will you reduce or remove any negative Impacts that you have identified?</p>
<p><b>Guidance for Completion</b></p> <p><i>In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered ‘Yes’, you need to indicate if the potential impact will be positive or negative. <b>Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.</b></i></p> <p><i>The information that helps to inform the assessment should be listed in this column. <b>Please provide evidence for all answers.</b></i></p> <p><b>Hint/tip: do not say: “not applicable”, “no impact” or “regardless of...”. If you have identified ‘no impact’ please explain clearly how you came to this decision.</b></p>			

# Part A

## Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

<p><b>NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect.</b></p> <p><b>For the definitions of each characteristic please click <a href="#">here</a></b></p>						
	Yes	No	(+ve)	(-ve)		
Age	x		x		<p>The policy seeks to ensure antimicrobials are used in an appropriate and prudent way to ensure patients are not exposed to unnecessary treatment and the development of antibiotic resistance is minimised. This is applicable for patients of all ages.</p> <p>However, there are variations in prescribing for older adults (who may for example, have trouble swallowing due to dysphagia which is common for individuals with dementia) or paediatrics. Whilst the policy will identify/reference both of these variances, the detailed guidance on administration is contained with subordinate procedures that the policy will signpost to.</p>	No negative impacts identified. However, variations in practice/administration, depending on patient age, is necessary. Specific reference to 'unsafe swallow' and paediatrics within policy.
Disability	x		x		Data shows that in most cases, patients with resistant infections require significantly longer hospital stays, more doctors visits, and lengthier recuperations and experience a higher incidence of long-term disability ( <a href="#">C. Lee Ventola, The</a>	Specific reference to 'unsafe swallow' within policy.

# Part A

## Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

				<p><a href="#">Antibiotic Resistance Crisis, Pharmacy and Therapeutics Journal, v.40 (40) 2015.)</a></p> <p>Good antimicrobial stewardship reduces the development of antibiotic resistance, the complications of which can lead to common infections and minor injuries causing unnecessary death or significant and/or permanent disability. The policy seeks to prevent and/or minimise the occurrence of this.</p> <p>As previously noted, individuals with dementia may experience difficulty with swallowing oral medication. The policy will identify this under initial indications for intravenous antimicrobials.</p>	
Gender Reassignment		x		<p>The assessment is that there is insufficient research, and no evidence of implications or negative impacts related to treating patients with antimicrobials who are undergoing, or have undergone gender reassignment.</p>	No negative impacts identified.
Pregnancy and maternity	x		x	<p>Antibiotic prescribing is widespread in pregnancy. However, altered drug handling due to pregnancy and/or breast-feeding may require dosage adjustment or alternative antimicrobials. There is also evidence that younger women and women from deprived areas were most likely to receive antibiotics in pregnancy (<a href="#">Irene Petersen, Ruth Gilbert, Stephen Evans, Antonia Ridolfi, Irwin Nazareth: Oral antibiotic prescribing during pregnancy in primary care: UK population-based study, Journal of Antimicrobial</a></p>	Specific reference for altered drug handling due to pregnancy / breast-feeding, within policy.

# Part A

## Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

				<p><a href="#">Chemotherapy, Volume 65, Issue 10, October 2010, Pages 2238–2246</a>). The Policy will direct prescribers to the British National Formulary or the Pharmacy department for advice when prescribing during pregnancy.</p> <p>Staff returning from maternity leave must receive a local return to work induction to update them of any changes during their absence, this includes updates to policies and procedures.</p>	
Race		x		<p>There is limited evidence as to the relationship between ethnicity and antibiotic resistance or prescribing. Detailed exploration of the attitudes and expectations of patients from different ethnic groups regarding antibiotics is also largely unreported. Various cultural factors may determine the likelihood of patients from different ethnic groups consulting their GPs with acute illnesses or receiving antibiotics. Afro-Caribbean patients are reported to self-administer medication more frequently than white or Asian patients before consulting. Older Asian Gujarati patients have also been found to consult with their GPs less often than older white patients because of poorer understanding of health services and greater availability of alternative sources of support. Therefore, it is likely that the relationship between patient ethnicity and antibiotic prescribing is highly context-dependent (<a href="#">Wang KY, Seed P,</a></p>	<p>The variance in antibiotic prescribing amongst different ethnicities can largely be explained by patient consultation behaviour. This is outside the scope of the policy, which is targeted at ensuring antimicrobial prescriptions are appropriate and regularly reviewed once an infection is identified.</p>

# Part A

## Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					<a href="#">Schofield P, Ibrahim S, Ashworth M. Which practices are high antibiotic prescribers? A cross-sectional analysis. Br J Gen Pract. 2009;59(567)).</a>	
Religion, belief and non-belief		x			<p>Of particular note within medical treatment and medicines management is the respect for the right to private and family life (article 8) and right to freedom of religion (article 9). These are relevant when considering consent to treatment and the administration of medication that may contain products that are prohibited by the individual's religion or belief.</p> <p>There are no animal products (a recent <a href="#">employment tribunal</a> has ruled that being vegan, for ethical reasons, amounts to a 'philosophical belief' and is therefore protected by the provisions of the Equality Act 2010) or alcohol contained in the preparations. Therefore, the assessment is that there are no negative impacts associated with the administration</p>	No negative impacts identified.
Sex		x			A recent meta-analysis across primary care in nine high-income countries found that women received more antibiotics than men in all age groups except those >75, with women aged 16–54 receiving 36%–40% more antibiotics than men of the same age. Similarly, across English and Welsh primary care, the rate of antibiotic prescribing has been found to be 40% higher in female	<p>No negative impacts identified.</p> <p>Whilst there is evidence of variances in prescribing between men and women, research is limited and the gender gap in antibiotic</p>

# Part A

## Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

				<p>than in male patients. Although the latter figure dates from 1996, gender disparities in England have more recently been observed in out-of-hours and paediatric care, with women and girls receiving more antibiotic prescriptions than men and boys. There are several proposed explanations for this gender gap. First, some infectious diseases affect men and women differently. In particular, urinary tract infection (UTI) is more common in adult women than in men and accounts for over 20% of antibiotic prescriptions in English primary care. However, respiratory tract infections (RTI) account for more than twice as many prescriptions as UTIs and women are not more susceptible to these conditions than men.</p> <p>In addition, women in the UK consult their general practitioner (GP) more often than men and consultation rate is linked to antibiotic prescribing. Ultimately, it remains unknown to what extent these and other factors combine to explain the gender gap in antibiotic prescribing (<a href="#">Smith DRM, Dolk FCK, Smieszek T, et al, Understanding the gender gap in antibiotic prescribing: a cross-sectional analysis of English primary care, BMJ Open 2018</a>)</p>	<p>prescribing can largely be explained by patient consultation behaviour. This (type of infection and willingness to consult) is outside the scope of the policy, which is targeted at ensuring antimicrobial prescriptions are appropriate and regularly reviewed once an infection is identified.</p>
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## Part A

### Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Sexual orientation		x			The assessment is that there is insufficient research, and no evidence of implications or negative impacts related to patient sexual orientation.	No negative impacts identified.
Marriage and civil Partnership (Marital status)		x			The assessment is that there is insufficient research, and no evidence of implications or negative impacts related to a patient's marital status.	No negative impacts identified.
Socio Economic Disadvantage	x		x		<p>Antibiotic-resistant infections add considerable costs to the health care system. When first-line and then second-line antibiotic treatment options are limited or unavailable, health care professionals may be forced to use antibiotics that are more toxic to the patient and frequently more expensive.</p> <p>Some GPs report a lower threshold for prescribing antibiotics for patients if they have poor nutrition and live in poor, overcrowded housing because of concerns about their increased susceptibility to bacterial complications. However, a recent study found that increased deprivation in the education, skills, and training domain of the IMD-2004 had a stronger association with high antibiotic prescribing than deprivation in other domains, although European studies have shown that this association varies according to geographical location (<a href="#">Smith DRM, Dolk FCK, Smieszek T, et</a></p>	



# Part A

## Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					<p><a href="#">al, Understanding the gender gap in antibiotic prescribing: a cross-sectional analysis of English primary care, BMJ Open 2018</a>). The policy forms part of BCUHB's quality improvement strategy for patient safety, providing a framework for staff to follow to help reduce inappropriate prescribing and optimise antibiotic use which may be particularly beneficial to those with increased susceptibility to bacterial complications.</p> <p>There is no cost associated with the treatment other than transport to site for administration. Patients with low income are eligible for travel reimbursement via the Finance General Office / F09: Reimbursement of Travel to Hospital Costs.</p>	
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## Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

**Please answer all questions**

### **Human Rights:**

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: <http://howis.wales.nhs.uk/sitesplus/861/page/42166> and for additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker <https://humanrightstracker.com>.

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2*      *Right to life*
- *Article 3*      *Prohibition of inhuman or degrading treatment*
- *Article 5*      *Right to liberty and security*
- *Article 8*      *Right to respect for family & private life*
- *Article 9*      *Freedom of thought, conscience & religion*

Please also consider these United Nations Conventions:

[UN Convention on the Rights of the Child](#)

[UN Convention on the rights of people with disabilities.](#)

[UN Convention on the Elimination of All Forms of Discrimination against Women](#)

## Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	No	(+ve)	(-ve)			
x		x			<p>The procedure applies equally to all patients but as with other medicines, patients have the right to refuse treatment in accordance with article 8 of the Human Rights Act 1998 (consent is comprehensively covered by BCUHBs Consent Policy - MD01).</p> <p>Article 2 imposes a positive duty on the State (including the NHS) to protect life. Antimicrobials are life saving and the policy supports the Health Board to exercise its duty under Article 2.</p> <p>There are no animal products or alcohol contained in the preparations. This ensures that the policy supports individual's rights under article 8 and 9 and they are not excluded from treatment.</p>	No negative impacts identified. There may be some instances whereby a patient is unconscious or unable to consent to receiving antimicrobials due to being extremely unwell (i.e. sepsis). In these circumstances treatment would be administered under the doctrine of necessity and in the patients best interests.

## Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

### Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	x		x		Once approved this policy will be submitted for translation. Antimicrobial prescribing resources such as the 'Start Smart then Focus' poster available in Welsh and English.	No negative impacts identified.
Treating the Welsh language no less favourably than the English language		x			As per above	No negative impacts identified.

## Part A Form 4: Record of Engagement and Consultation

### Please answer all questions

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

<p>What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.</p> <p><i>for further direction on how to complete this section please click <a href="#">here training vid p13-18</a></i></p>	<p>A full consultation was done with the teams and medical consultants using this policy. Feedback received on both the policy and the EqIA as the documents progressed through the approval groups with multi-disciplinary representation.</p>
<p>Have any themes emerged? Describe them here.</p>	<p>Variance in prescribing for some older adults, dementia, paediatrics and pregnancy. Higher prescribing in some groups though this is largely attributed to patient consultation behaviour and attitudes.</p>
<p>If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?</p>	<p>Explicit reference to patient who may have difficulty swallowing as well as paediatrics and pregnancy.</p>

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- <http://howis.wales.nhs.uk/sitesplus/861/page/44085>

## Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) <i>for further direction on how to complete this section please click <a href="#">here training vid p13-18</a></i>	<b>Antimicrobial Prescribing Policy MM10</b>
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2. Brief Aims and Objectives: (Copy from Form 1)	<p>The major change to our antimicrobial prescribing policy is to include the ARK principles now being adopted throughout the acute sites in BCUHB, and ensuring good antimicrobial stewardship.</p> <p>The aim of this policy is to support evidence-base best practice, limiting unnecessary use or overly prolonged courses of antimicrobials and reducing the development of antibiotic resistance and adverse effects of antibiotics including healthcare associated infections such as <i>C. difficile</i> infection. The Start Smart then Focus (SStF) approach is recommended by the Department of Health and supported by Public Health Wales. The ARK stewardship process is also supported throughout NHS Trusts and Health Boards in the United Kingdom</p>
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From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? <b>Guidance: This is as indicated on form 2 and 3</b>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? <b>Guidance: If you have completed this form correctly and</b>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

## Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>reduced or mitigated any obstacles, you should be able to answer 'No' to this question.</p>		
<p>3c. Is your policy or proposal of high significance? <b>For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?</b></p> <p>High significance may mean:</p> <ul style="list-style-type: none"> <li>- The policy requires approval by the Health Board or subcommittee of</li> <li>- The policy involves using additional resources or removing resources.</li> <li>- Is it about a new service or closing of a service?</li> <li>- Are jobs potentially affected?</li> <li>- Does the decision cover the whole of North Wales</li> <li>- Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions.</li> </ul> <p>GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/</p>	<p>Yes <input checked="" type="checkbox"/></p>	<p>No <input type="checkbox"/></p>

## Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes <input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	How is it being monitored?	Audit plan and reporting to WG
	Who is responsible?	All prescribers via Antimicrobial Steering Group
	What information is being used?	WG reports annually an tier 2 audits



## Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	When will the EqIA be reviewed?	Alongside the policy review (three year review cycle from date of approval).
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7. Where will your policy or proposal be forwarded for approval?	ASG, D&TG, QSG and QSE
------------------------------------------------------------------	------------------------

8. Names of all parties involved in undertaking this Equality Impact Assessment – <b>please note EqIA should be undertaken as a group activity</b>  Senior sign off prior to committee approval:	Name	Title/Role
	Charlotte Makanga .	Consultant Antimicrobial Pharmacist
	<i>Name of senior sign off prior to committee approval</i>	Dr Berwyn Owen
<b>Please Note: The Action Plan below forms an integral part of this Outcome Report</b>		

### Action Plan

## Part B Form 5: Summary of Key Findings and Actions

### Please answer all questions

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
	<b>Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.</b>		
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No negative impacts identified, acknowledged variants are recorded in subordinate guidance		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	N/A		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	N/A.		

## Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions  Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.	Who is responsible for this action?	When will this be done by?
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A.		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Variants such as pregnancy, paediatrics and patients with swallowing difficulties will be recorded in subordinate guidance		



Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	Quality, Safety & Experience Committee 4 <sup>th</sup> May 2021				
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public				
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	Committee Annual Report 2020-21				
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Mrs Gill Harris, Executive Director of Nursing and Midwifery				
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Mrs Kate Dunn, Head of Corporate Affairs Mrs Lucy Reid, Committee Chair				
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	The Committee Annual Report has been scrutinized by the Committee Chair and Lead Executive				
<b>Atodiadau</b> <b>Appendices:</b>	1. Committee Annual Report				
<b>Argymhelliad / Recommendation:</b>					
The Committee is asked to:					
1. Review the draft Annual Report for 2020-21					
2. Provide comments and feedback as necessary					
3. Agree that Chair's Action can be taken if necessary before submission to Audit Committee					
Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)					
<b>Ar gyfer penderfyniad /cymeradwyaeth</b> <b>For Decision/ Approval</b>	<input checked="" type="checkbox"/>	<b>Ar gyfer Trafodaeth For Discussion</b>	<input type="checkbox"/>	<b>Ar gyfer sicrwydd For Assurance</b>	<input type="checkbox"/>
				<b>Er gwybodaeth For Information</b>	<input type="checkbox"/>
<b>Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol</b> <b>Y/N to indicate whether the Equality/SED duty is applicable</b>					<b>N</b>
<b>Sefyllfa / Situation:</b>					
Committee input to the Annual Report for 2020-21 is sought.					
<b>Cefndir / Background:</b>					
A BCU-wide template for all Committee and Advisory Group Annual Reports has been developed for 2020-21 however the QSE Chair and Lead Executive made some local amendments to better reflect the challenges of the past year in terms of the Committee's focus on quality and safety relating to the pandemic and post pandemic response.					
The Annual Report will be submitted to a workshop meeting of the Audit Committee to be held on the 25 <sup>th</sup> May 2021.					
<b>Asesiad / Assessment &amp; Analysis</b>					

**Risk Analysis**

The report contains references to risks identified throughout the year.

**Legal and Compliance**

The Committee is required to produce an annual report which forms part of a composite report to the full Health Board.

There are no relevant matters to highlight relating to strategy, finance, and impact assessment



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University Health Board

## Committee Annual Report 2020-21

### 1. Title of Committee/Group/Forum:

Quality, Safety Experience Committee

### 2. Name and role of person submitting this report:

Mrs Gill Harris, Executive Director of Nursing and Midwifery

### 3. Dates covered by this report:

01/04/2020-31/03/2021

### 4. Number of times the Committee met during this period:

The Committee was routinely scheduled to meet 6 times and otherwise as the Chair deemed necessary. During the reporting period, it met (virtually) on 7 occasions in response to the need to balance the need to ensure quality and safety matters continued to be addressed during the Covid-19 pandemic, and ensuring that agendas were focused to free up operational time. Attendance at meetings is detailed within the table below. Attendance for Executive Directors and lead officers was limited by agreement of Committee Members and in accordance with Welsh Governance guidance to maximise capacity for the pandemic response.

Members of the Committee	5.5.20	3.7.20	29.7.20	28.8.20	3.11.20	15.1.21	2.3.21
<b>Independent Members</b>							
Lucy Reid (Chair)	P	P	P	P	P	P	P
Cheryl Carlisle	P	P	P	P	P	P	P
Jackie Hughes	P	P	P	P	P	P	P
Lyn Meadows	P	P	A	P	P	P	P

<b>Formally In attendance (as per Terms of Reference)</b>	<b>5.5.20</b>	<b>3.7.20</b>	<b>29.7.20</b>	<b>28.8.20</b>	<b>3.11.20</b>	<b>15.1.21</b>	<b>2.3.21</b>
<b>Directors</b>							
Gareth Evans Chair of Healthcare Professionals Forum	X	X	P	A	P*	P	P
David Fearnley Executive Medical Director (left BCU on 30.9.20)	P	X	P	P	◆	◆	◆
Sue Green Executive Director of Workforce & OD	X	X	P	P	P*	A	P
Arpan Guha Acting Executive Medical Director from 1.10.20	◆	◆	◆	◆	A	P	P
Gill Harris Executive Director of Nursing & Midwifery (note was Acting CEO from 1.9.20 to 31.12.20 so not a member of QSE at that time)	P	P	P*	P	◆	P	P*
Debra Hickman Acting Exec Director of Nursing & Midwifery from 1.9.20 to 31.12.20	◆	◆	◆	◆	P	◆	◆
Teresa Owen Executive Director of Public Health	X	X	A	P	P*	A	P*
Chris Stockport Executive Director of Primary & Community Services	X	X	X	A	P*	A	P
Adrian Thomas Executive Director of Therapies & Health Sciences	X	X	P	P	P	A	P
Representative for Mental Health & Learning Disabilities (in addition to Exec Lead) <sup>1</sup>	P	X	X	P*	P*	P	X

<sup>1</sup> : A number of interim arrangements were in place throughout 2020-21

**Key:**

P - Present

P\* - Present for part meeting

A - Apologies submitted

X - Not present

◆ Not a member of the Committee at this time.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee. For a full list of attendance, please see the approved minutes which can be accessed on the Health Board's website via the following pages:- <https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/>

**5. Assurances the Committee is designed to provide:**

The Committee is designed to provide assurance to the Board on the following key areas as set out in its Terms of Reference "to provide advice and assurance to the Board in discharging its functions and meeting its responsibilities with regard to quality, safety, patients and service user experience of health services." During the period that this Annual Report covers, the Committee focused on quality and safety relating to the pandemic and post pandemic response. The cycle of business was adjusted accordingly. The Terms of Reference are appended at Appendix 1.

Furthermore, a fundamental review of the Governance Structures has been undertaken by the Interim Director and Governance. This work is being finalised at the point of producing this Annual Report.

The Committee is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there were 2 breaches of this nature (for the months of May 2020 and August 2020).

**6. Main tasks completed / evidence considered by the Committee during this reporting period:**

The Committee received a range of standing and regular items. The agenda setting process with the Chair and Lead Executive also allowed for flexibility to bring ad-hoc papers to the Committee such as those where assurances were requested against a current risk or issue, an all Wales issue requiring local consideration, or to ensure governance and scrutiny of an issue ahead of a forthcoming Health Board meeting. The main themes of these substantive reports in 2020-21 is as follows:-

- Infection prevention and health and safety updates to the Committee during the year were more focused in terms of the impact of the pandemic. They included reports on avoidable infections, cluster outbreaks of Covid-19 amongst staff, post infection reviews and estates issues. The Committee requested that lessons identified as part of the cluster investigations be disseminated as a matter of urgency across all areas of the Health Board, primary care and care homes. The Committee also confirmed its clear support for requiring the wearing of face coverings in healthcare settings.



- The Committee expressed ongoing concerns around the need to undertake robust investigations and rapid reviews for serious incidents, and the need to improve and be able to demonstrate organisational learning arising from incidents. An improved level of corporate oversight on incident reporting and a review of the investigation processes were progressed in-year. Further work on this is needed and an improved governance process around the commissioning of investigations has been agreed.
- In terms of risk management the Committee welcomed the development of the Board Assurance Framework and the refreshed Corporate Risk Register. The Committee had remaining concerns regarding clarity and consistency in scoring, together with a need to review the organisation's risk appetite. A suggestion was made by the Committee that this be considered at a Board level workshop.
- An exception report to the Committee highlighted the current risks across the Mental Health and Learning Disabilities Division including vacancies across the leadership team and the need to plan for the anticipated increase in demand in services. A later report to the Committee was welcomed in that it demonstrated progress in a number of areas. The Committee continued to require the Division to report on a regular basis and to focus papers on key areas of concern – for example engagement with stakeholders and capacity.
- The Committee were keen to ensure that action plans from future significant quality-related reports (such as the Holden report and HASCAS/Ockenden review) were appropriately tracked. As a result it was agreed to utilise the same internal governance framework and methodology of that used for Healthcare Inspectorate Wales actions. In addition the Committee would also receive clear close down reports when all actions are complete and proactive periodic follow up to ensure actions have been sustained.
- The Committee received regular updates on vascular services and the associated external review. The Committee requested that once the review report had been received that a robust implementation plan with critical oversight would be essential.

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following pages

<https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/>

## **7. Key risks and concerns identified by this Committee in-year which have been highlighted and addressed as part of the Chair's reports to the Board:**

<b>Meeting Date</b>	<b>Key risks including mitigating actions and milestones</b>
Combined report for 5.5.20 and 3.7.20	<ul style="list-style-type: none"> <li>• There is a reduction in urgent and suspected cancer referrals and reduced access to screening and diagnostics, in particular endoscopy, as a result of COVID-19. Cancer teams are working with patients to provide support for patients. The</li> </ul>

	<p>Committee will receive an update on services at the next meeting as plans for Phase 2 are reviewed;</p> <ul style="list-style-type: none"> <li>• It was noted that the backlog of waiting lists is increasing as a result of non-essential services being suspended as a result of the pandemic. Although this is a national issue being experienced by all health services, the Committee has sought assurance that the Health Board is utilising every opportunity to maximise capacity as part of the Phase 2 planning;</li> <li>• Concern was raised with regard to the number of avoidable infections and cluster outbreaks of COVID-19 amongst staff. The Committee requested that lessons identified as part of the cluster investigations be disseminated as a matter of urgency to ensure that they are communicated across the Health Board and all areas including primary care and care homes;</li> <li>• The need to be able to undertake robust investigations and rapid reviews for serious incidents and demonstrate learning arising from these was identified. It was noted that a review is being undertaken of the investigation processes to ensure focus on human factors and organisational learning;</li> <li>• The Committee received a verbal update on the Vascular Services review and CHC report. The report has been discussed with the CHC and would be presented to the May Board. The importance of a robust implementation plan with critical oversight was agreed and the Committee would submit questions to the Executive Medical Director upon reviewing both reports;</li> <li>• A report was provided on the current status of ophthalmology services and performance against the eye care measure. It was noted that the risk stratification process undertaken for this patient cohort had identified a significant number of patients at high risk of eye sight loss. Work was underway to manage the urgent eye care pathway with optometrists to reduce the potential risk of harm. This had been affected by the pandemic;</li> <li>• A number of concerns were highlighted in relation to the corporate risks allocated to the Committee for oversight including the need for a clear audit trail for updates and changes and clarity of scoring. The Committee noted the review of the risk register and related strategy that was currently underway;</li> </ul>
<b>29.7.20</b>	<ul style="list-style-type: none"> <li>• The Committee voiced concerns about the use of face coverings for patients and the public in healthcare settings. Post infection reviews had been undertaken to identify learning from health acquired COVID-19 infections. Estates issues were still apparent on a ward in Ysbyty Glan Clwyd and the Committee requested an urgent update be provided.</li> <li>• The Committee raised concerns again about the mortality review report and lack of assurance about the process. It was</li> </ul>

	<p>agreed that the Committee would receive a further report at the August meeting addressing these concerns.</p> <ul style="list-style-type: none"> <li>• The challenges around maintaining essential services during the COVID-19 pandemic were highlighted. The added requirements for social distancing and infection prevention controls had a significant impact upon capacity. It was noted the service needed to continue monitoring activity and compliance with the revised essential services guidelines in order to mitigate the risk of harm.</li> <li>• The Committee received an update on the resetting and recovery of services and noted the significant challenges that the Health Board were facing. The service is undertaking risk stratifications of waiting lists to manage patient referrals on a risk basis rather than just based upon the longest waits. The waiting list management report was deferred to the next meeting</li> </ul>
<b>28.8.20</b>	<ul style="list-style-type: none"> <li>• The Committee noted ongoing concerns about the need to improve and be able to demonstrate organisational learning arising from incidents. An improved level of corporate oversight on incident reporting was being progressed to address this and a review was being undertaken.</li> <li>• An exception report highlighted the current risks across the Mental Health and Learning Disabilities Division including vacancies across the leadership team and the need to plan for the anticipated increase in demand in services. It was also noted that the psychological therapies review had been paused during the pandemic but that this would need to be commenced again.</li> <li>• The challenges restarting services across secondary care were noted using a risk stratification approach. The winter surge plans were under development and should be aligned with planned and unscheduled care work.</li> </ul>
<b>3.11.20</b>	<ul style="list-style-type: none"> <li>• The Committee noted capacity issues with the Infection Prevention and Control team and the impact that the pandemic has also had on the team. A business case to increase resource and capacity within the team had received Executive support and recruitment would be progressed;</li> </ul>
<b>15.1.21</b>	<ul style="list-style-type: none"> <li>• The Committee reviewed the corporate risk register and challenged some of the target risk dates and actions recorded.</li> <li>• The Committee were not assured that the risks were being managed effectively or that adequate scrutiny had been provided by the Risk Management Group due to the number of issues identified by members in the register. The Interim Director of Governance agreed to receive detailed feedback to address the Committee's concerns.</li> <li>• The Committee noted the deterioration in community acquired infections and it was confirmed that this was being pursued through accountability reviews and that clinical leadership and the local infection prevention groups were key to improvement</li> </ul>

	<p>being achieved. The outbreaks in care homes was also discussed and the Committee informed that support was being provided and a daily reports were received by the Executive Incident Management Team.</p> <ul style="list-style-type: none"> <li>• There had been an increase in the number of RIDDORs reported in quarter 3, the majority of which related to staff testing positive for Covid-19. Themes had been identified from the reviews which included non-adherence to social distancing and PPE. The Committee were informed that work was ongoing to address behavioural aspects of the non-compliance.</li> <li>• The Committee received a report on the findings of a comprehensive review that had been undertaken on the implementation of actions arising from the Holden report issued in 2013. Whilst action had been taken at the time in response to the report, it was accepted that some of the same issues had recurred within the Division albeit in different circumstances and different outcomes. The Committee supported the proposal for a strengthened governance process around tracking action plans for all future significant quality related reports and clear close down reports being provided when actions had been implemented.</li> <li>• The Committee discussed the quality governance review that had been undertaken for Ysbyty Glan Clwyd and noted that the site had been asked to provide a detailed improvement plan, which would be received at a future meeting.</li> </ul>
<b>2.3.21</b>	<ul style="list-style-type: none"> <li>• The Committee received the latest version of the Board Assurance Framework and Corporate Risk Register and highlighted a number of areas that required strengthening. The Committee did not support the inclusion of CRR20-09 (diabetes) to the Corporate Risk Register</li> <li>• An update was received on the Covid-19 outbreak in Ysbyty Gwynedd and whilst the numbers of infections were reducing, there was further work required to ensure actions were sustainable. An external review was being commissioned to identify learning from the outbreak and this will be reported to the QSE Committee when completed</li> <li>• The Committee were informed of the death of another member of staff as a result of Covid-19, taking the total to four. One of these deaths is the subject of an investigation by the Health and Safety Executive. The requirements of the previous Improvement Notice issued against the Health Board have been completed and evidence submitted to the Health and Safety Executive. The Committee have requested themes arising from Make It Safe reviews and subsequent remedial actions should be more visible in future reports</li> <li>• The Committee received an update on the work of the Vascular Services Task and Finish Group and noted the reported delay in agreeing the diabetic pathway. The</li> </ul>

	Committee were informed that a multidisciplinary group had been brought together to address this
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## **8. Review of Effectiveness**

The QSE Committee has continued to meet during the pandemic with a revised focus on Covid-19 related matters. The Committee provided increased scrutiny on healthcare acquired infections and health and safety in recognition of the increased risks in these areas. Focused reports on learning arising from the Wrexham Maelor outbreak were received and this will be followed up as part of the cycle of business for 2021/22. The improvements in leadership across the Mental Health and Learning Disabilities Division have been recognised and evidence provided that this is translating into improve patient experience as well.

Organisational learning remains an area requiring significant improvement and the Committee will be focusing on this in the following year. In addition, the growing risks arising from delayed care for patients as a result of the pandemic and mitigating actions will be monitored.

## **9. Focus for the year ahead:**

The primary focus of the Committee over the next twelve months will be:

- Evidence of improved governance and learning across the organisation following the implementation of the Board Assurance Framework and governance review;
- Safe restoration of services for patients based upon clinical risk and informed prioritisation;
- Service reviews and improvements such as Vascular Services and Urology Services;
- Organisational learning and implementation of improvement plans;

**Betsi Cadwaladr University Health Board**  
**Terms of Reference and Operating Arrangements**

**QUALITY, SAFETY AND EXPERIENCE COMMITTEE**

**1) INTRODUCTION**

- 1.1 The Board shall establish a committee to be known as the **Quality, Safety and Experience Committee (QS&E)**. The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

**2) PURPOSE**

- 2.1 The purpose of the Committee is to provide advice and assurance to the Board in discharging its functions and meeting its responsibilities with regard to quality, safety, patients and service user experience of health services.

**3) DELEGATED POWERS**

- 3.1 The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to:-

3.1.1 ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning;

3.1.2 ensure the adequacy of safeguarding and infection, prevention and control arrangements;

3.1.3 provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;

3.1.4 seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience;

3.1.5 ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:

- Sources of internal assurance (including clinical audit) are reliable
- Recommendations made by internal and external reviewers are considered and acted upon on a timely basis

- Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.

3.1.6 Receive assurances from the Quality Improvement Strategy and Legislation Assurance Framework to allow the Committee to review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements;

3.1.7 Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).

3.1.8 Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;

3.1.9 Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.

3.1.10 provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;

3.1.11 to receive periodic updates in respect of the workforce flu vaccination.

#### **4) AUTHORITY**

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3 It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Quality, Safety and Patient Experience matters.

- 4.4 It will review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place;

## **5) SUB-COMMITTEES**

- 5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

## **6) MEMBERSHIP**

### **6.1 Members**

Four Independent Members of the Board.

### **6.2 In attendance**

Executive Director of Nursing and Midwifery (Lead Executive)  
 Executive Medical Director  
 Executive Director of Therapies and Health Sciences  
 Executive Director of Primary Care & Community Services  
 Director of Performance  
 Executive Director of Workforce & Organisational Development  
 Executive Director of Public Health  
 Associate Director of Quality Assurance  
 Director of Mental Health & Learning Disabilities  
 Senior Associate Medical Director / 1000 Lives Clinical Lead  
 Chair of Healthcare Professionals Forum -Associate Board Member  
 Representative of Community Health Council

- 6.2.1 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

- 6.2.2 Trade Union Partners are welcome to attend the public session of the Committee

### **6.3 Member Appointments**

- 6.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.
- 6.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by



the Chairman of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

#### **6.4 Secretariat**

6.4.1 Secretary: as determined by the Board Secretary.

#### **6.5 Support to Committee Members**

6.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

### **7) COMMITTEE MEETINGS**

#### **7.1 Quorum**

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

#### **7.2 Frequency of Meetings**

7.2.1 Meetings shall be routinely be held on a bi-monthly basis.

#### **7.3 Withdrawal of individuals in attendance**

7.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

### **8) RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS**

- 8.1** Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.
- 8.2** The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,
- 8.3** The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

- 8.4** The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.
- 8.5** Receive assurance and exception reports from the Quality and Safety Group (QSG)

## **9) REPORTING AND ASSURANCE ARRANGEMENTS**

- 9.1** The Committee Chair shall:

9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report as well as the presentation of an annual report;

9.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

- 9.2** The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

## **10) APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS**

- 10.1** The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

**11) REVIEW**

- 11.1** These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

**Date of approval:**

Audit Committee 30.5.19

Health Board 25.7.19

V6.0



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	Quality, Safety and Experience Committee 4 <sup>th</sup> May 2021						
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public						
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	Summary of business considered in private session to be reported in public						
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Gill Harris, Executive Director of Nursing and Midwifery						
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Kate Dunn, Head of Corporate Affairs						
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	None						
<b>Atodiadau</b> <b>Appendices:</b>	None						
<b>Argymhelliad / Recommendation:</b>							
The Committee is asked to note the report							
Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>	<input type="checkbox"/>	<b>Ar gyfer Trafodaeth For Discussion</b>	<input type="checkbox"/>	<b>Ar gyfer sicrwydd For Assurance</b>	<input type="checkbox"/>	<b>Er gwybodaeth For Information</b>	<input checked="" type="checkbox"/>
<b>Sefyllfa / Situation:</b>							
To report in public session on matters previously considered in private session							
<b>Cefndir / Background:</b>							
Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.							
<b>Asesiad / Assessment</b>							
The Quality, Safety and Experience Committee considered the following matters in private session on 2.3.21							
<ul style="list-style-type: none"> <li>Discussion on quality governance review at Ysbyty Glan Clwyd</li> </ul>							

# Feeling forgotten?

Hearing from people waiting for  
NHS care and treatment during the  
coronavirus pandemic



# **Accessible formats**

This report is also available in Welsh.

If you would like this publication in an alternative format and/or language, please contact us.

You can download it from our website or ask for a copy by contacting our office.

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# About the Board and Community Health Councils

The Board of Community Health Councils (the Board) has produced this report on behalf of the 7 Community Health Councils (CHCs) in Wales.

CHCs are the independent watchdog of the National Health Service (NHS) within Wales. CHCs encourage and support people to have a voice in the design and delivery of NHS services.

CHCs work with the NHS, inspection and regulatory bodies. CHCs provide an important link between those who plan and deliver NHS services, those who inspect and regulate it and those who use it.

CHCs hear from the public in many different ways. Before the coronavirus pandemic, CHCs regularly visited NHS services to hear from people while they were receiving care and treatment. CHCs also heard from people at local community events, and through community representatives and groups.

Since the coronavirus pandemic, CHCs have focused on engaging with people in different ways.

This includes surveys, apps, videoconferencing and social media to hear from people directly about their views and experiences of NHS services as well as through community groups.

There are 7 CHCs in Wales. Each one represents the “patient and public” voice in a different part of Wales.



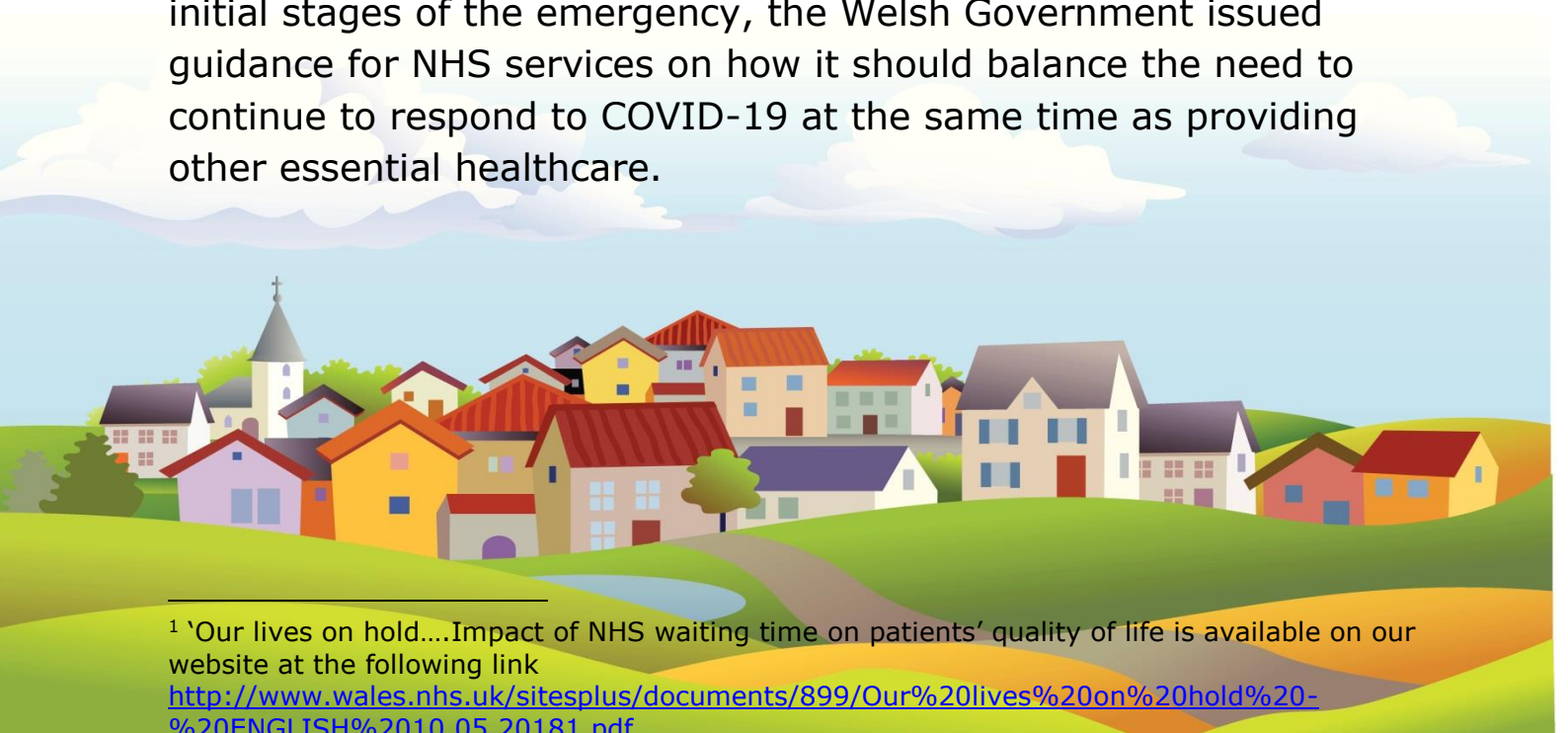
# Background & introduction

In 2018 we published our report 'Our lives on hold'<sup>1</sup>. The report described the impact on people living in Wales who were waiting a long time for NHS treatment. It identified that when we wrote our report, there had been some recent improvements in the time people had to wait for care and treatment.

The report also called for changes in the way the Welsh Government and the NHS judged how well the NHS was doing – so that the harm that can be caused by inactivity or “waiting too long” for care and treatment was included.

Since then, the coronavirus pandemic has changed everything. In March 2020 the Welsh Government took action to “continue to provide care and support to the most vulnerable people in our communities, whilst also making sure organisations and professionals were supported to prepare local responses to the public health emergency”.

For many people waiting for a diagnosis or treatment following their diagnosis, things were put on hold. As the NHS moved from the initial stages of the emergency, the Welsh Government issued guidance for NHS services on how it should balance the need to continue to respond to COVID-19 at the same time as providing other essential healthcare.



<sup>1</sup> 'Our lives on hold....Impact of NHS waiting time on patients' quality of life is available on our website at the following link  
<http://www.wales.nhs.uk/sitesplus/documents/899/Our%20lives%20on%20hold%20-%20ENGLISH%2010.05.20181.pdf>

It was identified that there were 4 types of harm that the NHS needed to focus on and guard against:

Harm from COVID-19 itself	Harm from an overwhelmed NHS and social care system
Harm from a reduction in non COVID-19 activity	Harm from wider societal actions / lockdown

Welsh Government said that essential services<sup>2</sup> should be maintained at all times throughout the pandemic, and that any backlogs must be urgently addressed.

It said that decisions to re-introduce routine services should be made “when it is safe and appropriate to do so”.

Making decisions about the risks of providing care and treatment during the pandemic involves clinical judgements. CHCs rely on other bodies to provide independent assurance on this.

This report focuses on what it has felt like for many people throughout the pandemic so far. It highlights the things we often heard from people living in Wales about the impact that delays in diagnosis or treatment are having – **in their own words**.

It will not reflect everyone’s experience. We know that people’s individual views and experiences are all different.

Our report doesn’t mean that people across Wales are not supportive of everyone working in the NHS throughout this

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<sup>2</sup> <https://gov.wales/sites/default/files/publications/2020-05/maintaining-essential-healthservices-during-the-covid-19-pandemic-summary-of-services-deemed-essential.pdf>

pandemic – their grateful thanks to healthcare workers continue for everything they have done and are doing.



### Our report also picks up on:

- how the NHS response has developed
- what it has done to respond to the things people were worried about early on
- what it is doing now and
- what it can do more of to make it easier for people to understand and manage through these difficult times.



# What we did

During the coronavirus pandemic, people across Wales have been able to share their views and experiences of NHS care with us by completing our national surveys.

The feedback we receive through these national surveys is only one way in which CHCs hear from people about their NHS services.

CHCs also find out about people's views and experiences in other ways:

- through enquiries coming into CHC offices
- stories being shared with the complaints advocacy service
- contacts with local community networks
- information coming in to us from community representatives and groups
- social media discussions
- monitoring of health board activities and performance.



So that services can respond quickly and appropriately, CHCs share with their health boards what they are hearing from people in their local communities on an on-going basis.

At a national level, the Board and CHCs across Wales meet with the Welsh Government every week to discuss what we are hearing across Wales and the actions needed.



We have heard regularly throughout the pandemic about the impact waiting for care and treatment is having on people and families. This report reflects the things we have heard through our national surveys and local CHC activities.

# Who we are hearing from

Here is a snapshot of the people who are sharing their views and experiences of NHS care during the coronavirus pandemic through our national surveys.



We do not always have the same kind of information about the people CHCs are hearing from directly because people do not always tell us everything about themselves when they come to share their experiences and views with us.

We heard from around **1,150** people through our national surveys.

Over **95%** shared their views and experiences in English

Over **three quarters** were women, and over **95%** were cisgender<sup>3</sup>

The youngest person we heard from was **21** and the oldest was **77**

Around **85%** identified as heterosexual

Around **90%** were White (Welsh, English, Scottish, Northern Irish, British)

Almost **40%** were carers

Almost a **quarter** had a disability or long term health condition

You can find out in our Equality Plan what we are doing to hear from different groups of people so that we can better represent the diversity of the communities we serve. You can find our Equality Plan on our website [www.communityhealthcouncils.org.uk](http://www.communityhealthcouncils.org.uk)

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<sup>3</sup> Cisgender is a term for people whose gender identity matches their sex assigned at birth

# What we heard

## In the early stages – postponing routine and planned care

In March, as the coronavirus pandemic started to take hold in Wales as well as the UK and beyond, all of us entered lockdown.

The NHS in Wales took action to respond to the emergency. In order to provide care for the growing number of people with COVID-19 and help stop people catching the virus, the decision was made to postpone all non-urgent NHS care and treatment.

People who were most at risk were asked to shield themselves at home. Urgent NHS appointments with General Practitioners (GPs) started to change quickly and in different ways, firstly by telephone and then videoconferencing.

During these early stages of the pandemic people understood the reasons why planned care, as well as routine care and treatment needed to be postponed.

In the early stages, some people told us they had heard from the NHS and were clear about what would happen.

**“I received a letter from the Physiotherapy Outpatient Department ..... telling me about the impact of the situation on my referral.**

**The letter says they are contacting all physiotherapy patients, and it includes a telephone number for urgent advice about muscle and joint problems. I have found this to be very helpful as I am now clear what is happening.”**

Many others were unsure about what would happen to their care and treatment across a wide range of services because no one told them what was happening.

## People waiting for a diagnosis or treatment

We heard from some people how a delay in their treatment was something that they understood because the reasons had been explained to them.

**"I was due to have a maintenance course of immunotherapy treatment on 25th March. This was cancelled. I was given a full explanation of the reasoning behind this by my urology nurse ....., and was told that a cystoscopy would be undertaken when it was possible to do so.**

**I have been very worried, especially when the government was proposing that this lockdown could continue until the end of the year. This morning I received a phone call ..... booking an appointment for me to have the cystoscopy .....I can't tell you the relief I feel."**





For many people who had been waiting for tests or a diagnosis before the pandemic, a lack of communication about their individual situation didn't help.

**"Was referred by GP for Ultrasound weeks prior to the Covid-19 situation - have received no communication whatever regarding the process and if it will go ahead when the situation settles. My understanding is that routine tests will no longer happen such as smear tests. Mine is due in the coming months but not aware of what will happen to those tests that will not occur during this pandemic."**



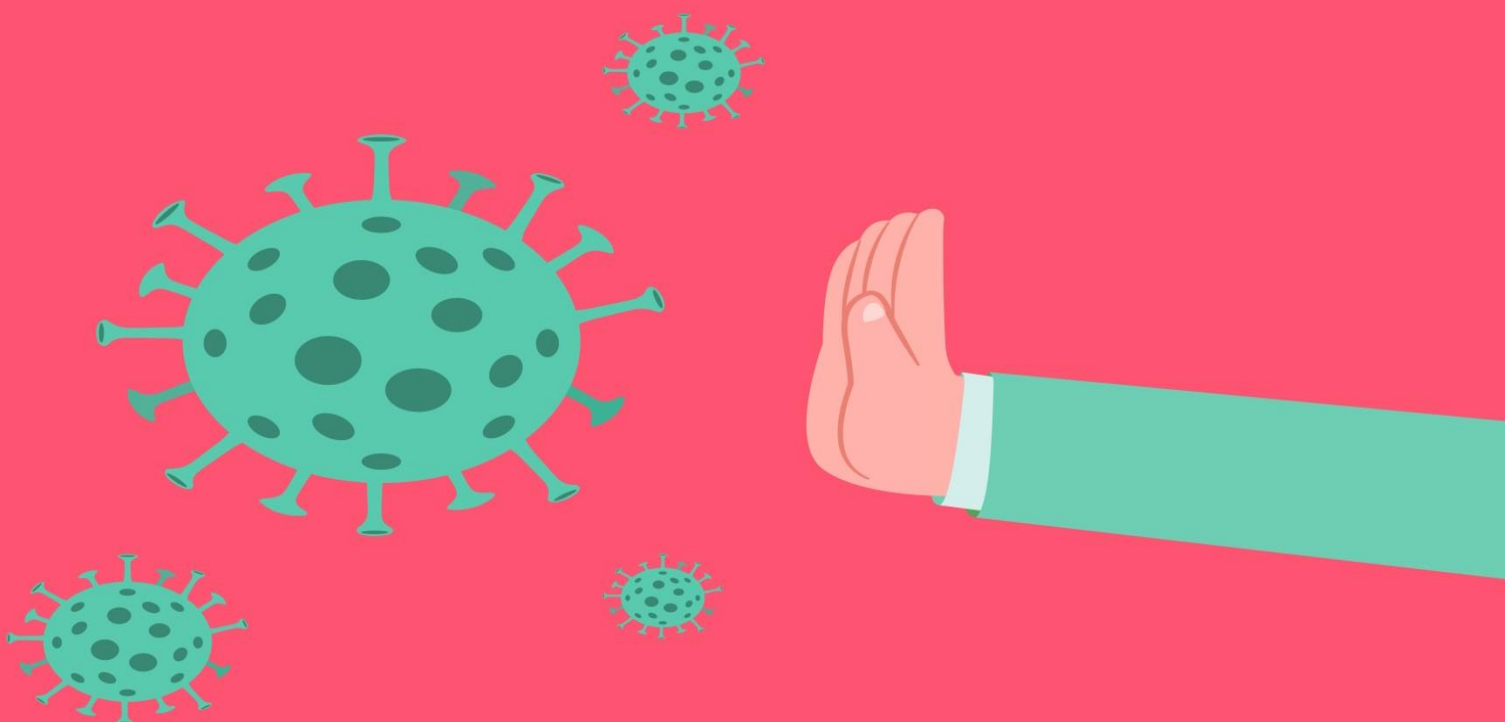
**"No result from a blood test over 2 months ago, appointment cancelled due to Covid-19"**



## People having cancer care

We heard from lots of people about what was happening with cancer care.

**"I obviously realise that in the current climate with the added pressures on the Health Board the situation is unprecedented and serious but feel that it must be managed so that possible cancer patients do not have their lives put at risk."**



Some people told us how well their treatment was continuing.

**“At present in middle of my course of treatment. Nurses have been incredible, kind caring, explaining changes in light of Covid19. They were professional and friendly at all times. They used PPE to keep us safe and measures to ensure we were well enough for treatment e.g. taking temperature in porch of unit.**

**Always kept updated of changes and asked if it was acceptable and satisfactory for me e.g., change of venue for blood tests. It was busier on one of days I was there but with two units combining it is expected. Everything ran smoothly and cannot praise staff enough. Also change in consultant appointment to telephone appointment which is sensible at this present time.”**



Even though the Welsh Government had said that urgent cancer care and treatment would continue, we heard that many people were anxious about delayed results or their on-going cancer care, and the impact on people's condition in the longer term.



**"I had a biopsy taken which was sent to the UHB for analyse. My GP advised that it could be skin cancer, since this I have had to attend surgery every other day to have my wound packed and dressed and as it is not healing, my GP upped their request for the results to urgent 4 weeks ago. It has now been 7 weeks since my biopsy was submitted and I am still waiting for the results, this is causing me to feel very stressed about my health condition."**

In some cases, it was not always clear to people why cancer treatment had been cancelled or postponed.

**"Firstly I would like to start by saying a big thank you for all the hard work that frontline NHS staff are doing in the fight against the COVID19 Coronavirus pandemic. However I am writing this letter of complaint regarding the treatment of my sister who has recently been diagnosed with a grade 2 breast cancer tumour. She along with many other cancer patients appear to be the forgotten ones by this Health Board in this current crisis.**

**She was due to have a mastectomy operation this week, but has just been informed by her nurse that all cancer operations ... have been cancelled this week. I appreciate the need to ensure we have the correct capacity at our hospitals for COVID19 patients, but when I am hearing stories from members of staff ..... about how quiet wards are and how many empty beds there are. It beggars belief that someone has taken the decision to cancel lifesaving cancer operations. In my sister own words " I feel like a ticking bomb" Is this really how any human being should be made to feel.**

**The average single mastectomy operation takes 90 minutes in theatre with the patient needing only one nights stay before being discharged the next day. By putting off these kinds of surgery you are increasing the patients risk of the cancer spreading and them then requiring re-assessment resulting in a more complex operation if the cancer has spread to the lymph nodes which results in them using more precious resources.**



## **People with postponed or cancelled operations**

Many people had already been waiting a long time for an operation even before the pandemic changed everything. Although they understood the reasons why their operations had been postponed or cancelled, the impact was often devastating.

**"Waiting for ovarian dermoid cyst removal. Attended Pre op date in October '19. An op date was given in January which was cancelled and then rearranged for April along with another pre op as previous had expired.**

**Symptoms have become increasingly difficult to manage leaving me with daily pain, tiredness, altered sensation to my left leg and overall has affected my mental health and wellbeing.**

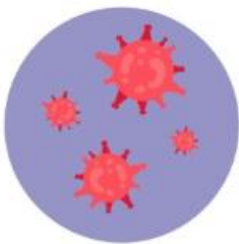
**Due to the coronavirus my operation and pre op were cancelled for April. This left me lost, angry and with nowhere to turn to. I went back to my GP in March who organised blood tests and ultrasound scan. A GP rang me to inform me that the cyst had tripled in size and to 'just put a hot water bottle on it and carry on with Codeine'. I ASKED for a copy to be sent to consultant.**

**I have rang every week for answers. No one will get back to me. Have been told today to 'hang fire' till July for another scan and will only operate if in pain!**

**"Had my operation cancelled twice after a 2 year wait now spending every day of lockdown in pain with 2 children at home as I'm a single parent"**



**"My daughter has a brachial cyst in her neck and was due an operation in March. It was cancelled due to the virus and has been steadily growing now to the point she cannot move her neck and she can feel it when swallowing. We are extremely worried that it could burst causing infection likely to be sepsis."**



**"My ex wife was due to have a procedure relating to a heart problem but when she arrived she found out from a minor technician that all these procedures where now cancelled. Nobody of note was available to explain.**

**As a result she has now been sick from work so long that she will soon stop getting paid her full wage and is very stressed and crying a lot. There is no new date for the procedure yet".**

Some people told us that things would have been easier if they had received better advice and information to help them manage while they were waiting.

**"As expected and appreciate and understand the cancellation of my Spinal Steroid Injection for pain management. No further information given. Has led to substantial increase in use of Morphine & Fentanyl.**

**It's severely impacted my mobility only getting 2 hrs a day out of bed due to excruciating pain. This in turn is impacting my mental health to a very low mood & zero motivation.**

**But I accept what his happening and just have to ride it out till things change and understand the strains my health trust is under so I'm not complaining. But wish some one had contacted me to discuss how to best manage my severe pain than leaving me fend for myself.**

**Offered no support whatsoever but understand that pressures are being felt at my hospital so not blaming anyone. It is what it is and am sure I will get my procedure as soon as it's safe to do so."**

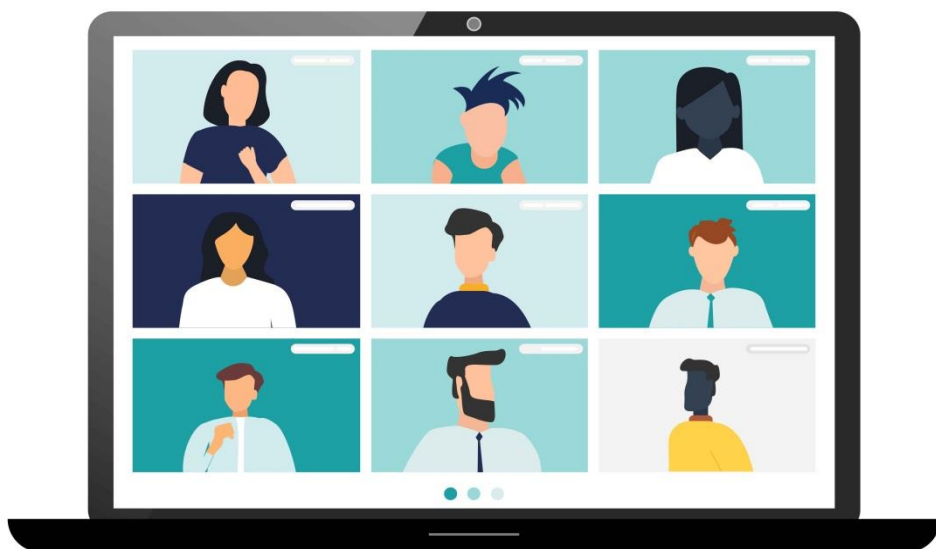


## People having routine care for life-long conditions

We heard that for some people, their on-going care had continued, although in a different way.

**"My on going care for IBD ..... has been brilliant. Any question I have had has been answered by email v quickly by the IBD nurses sometimes within the hour I can't thank them enough..."**

**"I had my diabetic review from home using video call this is all very new to me and I felt very uncomfortable about it before hand. After I was talked through everything and had the call I was left surprised on how well it worked."**



For many others, in the early stages of the pandemic their routine on-going care simply stopped. Sometimes, people were contacted a little later on with information about what might happen next.

**"COPD 23% lung function. All appointments stopped before my appointment at beginning of March for COPD check up. I've just been told they've been cancelled due to Covid 19, which is completely understandable.**

**I haven't been told if they will resume at any point and again as I am someone who has been shielding since I was ill in January I would not attend and appointment at the hospital anyway. I also was having fortnightly therapy sessions...., which owing to illness either myself or the therapist I haven't been to an appointment since December 2019.**

**She has rung me recently and stated there is a possibility of resuming our sessions via video link and will contact me when/if that becomes a reality. I haven't heard back from her in about a month so not available yet obviously."**



For others, we heard there was no clear advice and information about the changes or when they might be seen again.

We heard from lots of people who rely on routine **B12 injections**<sup>4</sup> about their concerns that their treatment was being changed.

**“Near the start of the Covid-19 lockdown situation, I received a letter from my GP surgery saying that they were switching IM B12 injections to oral supplements.**

**This was obviously understandable under the circumstances, although the dose prescribed was 50mcg rather than 1mg which is the quantity recommended by NICE (see attached guidelines).**

**I queried this at the time and ended up having to buy B12 supplements at the correct level privately, which is an unreasonable expense for a known serious condition which should be covered by the NHS, particularly as I am a medical student myself and therefore not on a high income.”**

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<sup>4</sup> **Pernicious anaemia** is an autoimmune condition that affects your stomach. An autoimmune condition **means** your immune system, the body's natural defence system that protects against illness and infection, attacks your body's healthy cells. Most people can be treated with B12 injections or tablets to replace the missing vitamins.

Many people were really worried about changing from injections to oral supplements, as they had been told before this would not be suitable for them.

This made people doubt the advice and knowledge of their healthcare staff, and some people told us they felt their concerns went unheard.

**"..... has pernicious anaemia. She relies on B12 injections & was due to have one next week. She told me that her surgery are refusing to give her the injection and have told her she needs to take tablets instead. .... says WHO advice is that patients should still be having these injections.**

**.....has suffered with neurological problems in the past and she informs me that this injection is a life-saving injection for her. Her body cannot absorb the tablet orally which is why she must have an injection. She has explained this to the doctor at the surgery to no avail."**

**"Diagnosed as deficient in B12 in 2016. Have been having 10 week b12 injections and told no oral replacement would work and told how important it was to keep on top. During covid19 my injections have stopped and was advised to supplement with over the counter tablets and I will be ok.**

**This goes against all information the GP has told me for the past 4 years. This has increased my anxiety alone and generally leaving me doubting the advice given me now or in the past."**

For people living with **life-long conditions** like **diabetes**, we heard worries that the lack of regular monitoring and annual check ups is leading to bigger problems. We heard that some people felt abandoned.

**"they must not forget people with long term conditions. We are being abandoned."**

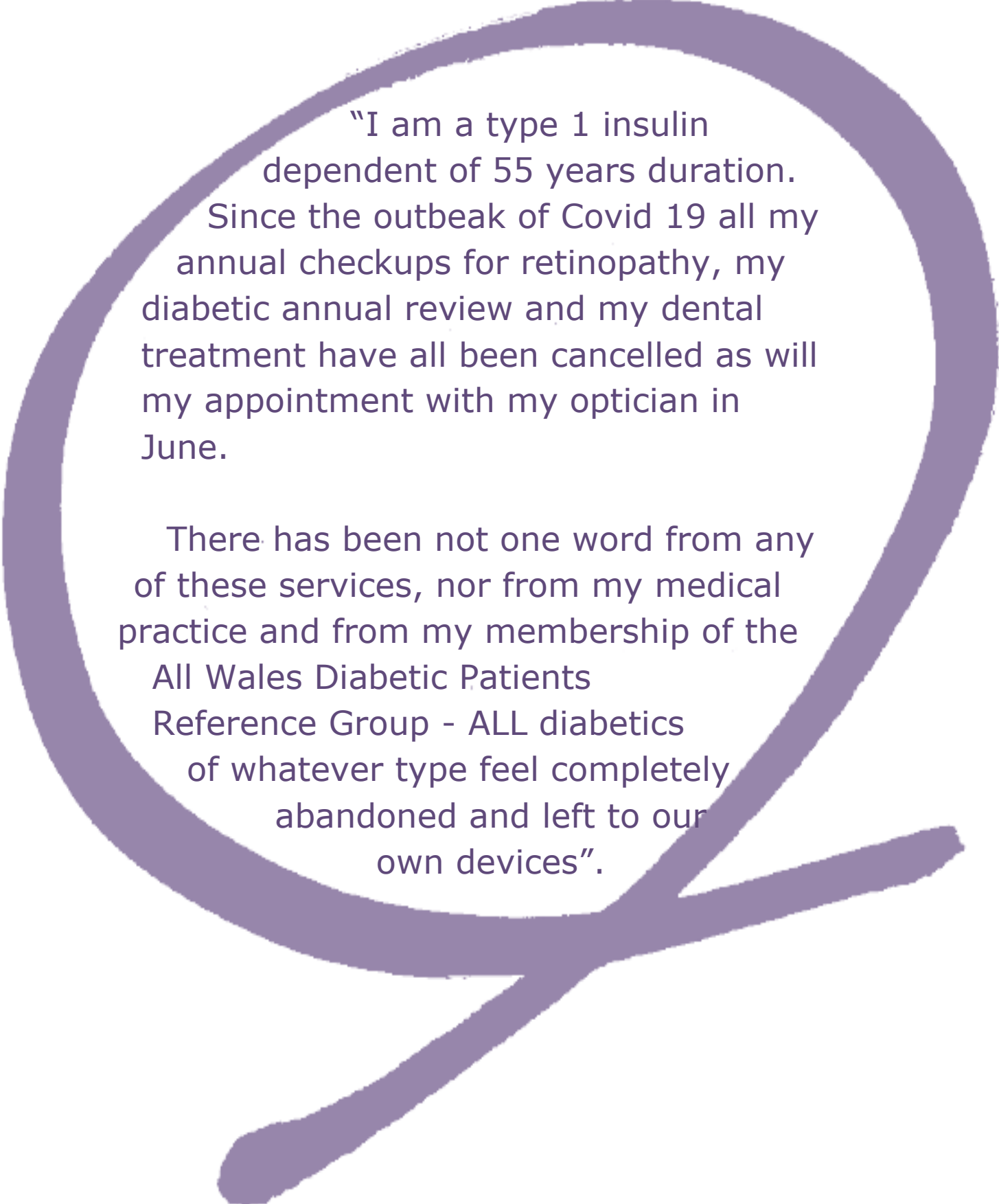
**"....letter to say all services postponed until further notice. Referred by podiatry about pressure area on foot and for potential review of footwear and caliper."**

**Also need to have shoes and caliper serviced regularly so as not to end up in position where I have nothing to wear and all appliance are in factory at the same time."**

**"My concern is that nothing routinely has been done, example 1 - my husband has not seen a diabetic nurse since last September, normally it used to be every 6 months, he has rang but the clinics were closed."**

**3 weeks ago I rang again, as he was due for annual checkup, they came and took a blood sample, shortly after a diabetic nurse rang and said she would put him in touch with a community diabetic nurse, she came last week and informed them he was having far too much insulin (cut intake by 10 units)."**

**This is the first check in over 12 months and feels he could have died."**



"I am a type 1 insulin dependent of 55 years duration. Since the outbreak of Covid 19 all my annual checkups for retinopathy, my diabetic annual review and my dental treatment have all been cancelled as will my appointment with my optician in June.

There has been not one word from any of these services, nor from my medical practice and from my membership of the All Wales Diabetic Patients Reference Group - ALL diabetics of whatever type feel completely abandoned and left to our own devices".

We heard that for some people, making decisions about whether to attend NHS places for check-ups would have been easier if they had better information.

**"I take my 90 year old mother for 6 - 8 weekly checks and injections at ..... clinic. My mother chose not to attend her next appointment as she is in a vulnerable category for Covid19.**

**She was contacted to see whether she still wanted the check but after discussion with me decided not to go ahead with the appointment. What would have been useful is more information regarding how this may impact her vision and to have a discussion in order to weigh the risks to make an informed decision.**

**Instead we were simply asked about the appointment. We hope we've made the right decision to protect her general health. But we simply don't know whether we've jeopardised her visual (and therefore her independence) health. More information would have been useful."**



## People needing follow up appointments after earlier care or treatment

We heard from some people that they were able to have great follow up care even though this was done in a different way.

**“Reason for the appointment was a blood test, which I need every 3 months following prostate cancer. Attending the surgery was different under present circumstances but the staff were careful and thorough. I also had an appointment for my Zoladex implant – again all went well, under present restrictions.”**





"The care during the pandemic has been amazing. The team have kept in regular contact via email / text messages / phone calls with any updates & have been offering Zoom meeting & virtual clinic appointments which have worked really well. They have even set up a virtual leisure centre which I've found so helpful during lockdown & shielding in order to maintain my lung health. Home spirometers were provided to be able to monitor my lung function at home. When I've had to visit the clinic for blood tests the staff have been really reassuring, wearing full PPE with robust procedures in place. I have been able to maintain access to all my medication that comes from the hospital & the Nurses were even bringing this to my car to prevent me having to enter the hospital.

The hospital has dedicated 2 parking spaces to CF patients which are by an entrance that's very near to the clinic, when I've needed to visit. Couldn't have asked for better care during a challenging time!"

For lots of people, we heard they had not had any follow up contact or appointments after the care or treatment they had received before the lockdown. This was a big worry for them.

**"my mum has chronic lymphocytic leukaemia and was due an appointment in April to check her bloods as they are climbing again. Obviously appointment was cancelled due to COVID like all other outpatient appointments but we don't know what happens next. No one has been in touch".**

**"I had no follow up sessions for my hip replacement in February because they were cancelled."**

For some people this was limiting what they do in their daily lives, as well as affecting their families and loved ones. For others, it was threatening their recovery.

**"Had to receive A&E care in May following which I was admitted to Cardiology. Care I received in Emergency department and on ward was excellent. However follow up care by GP was extremely difficult to access and resulted in several more visits to A&S for care reviews."**



**"I have been seeing a Dermatologist..... since January. I was prescribed Isotretinoin for acne. This includes blood and pregnancy tests each month. My March blood test was cancelled and so was my appointment with the Dermatologist in March due to Covid-19.**

**I was told I would be contacted but wasn't. After a week of ringing his secretary, I had to send a photo of my negative pregnancy test. I was then sent a prescription by post. Today I tried to email for another prescription only to be told it is only prescribed for 4 months.**

**I am very disappointed about this as I was told by my consultant it would be for 6 months. My skin is not better yet and I have suffered side effects since taking the tablets.**

**I have now just been left in the middle of treatment with no contact or follow up appointment. I had been waiting for about 8 months to see the Dermatologist and feel it has been a waste of time. I've just been left. Very disappointed."**

**"I am worried about my eye care. I have had some laser treatment that stopped me from being able to drive for a bit. Then all of this started and I think I have not had an appointment when I should have.**

**I am the only driver in the house, my wife is disabled and we are not shielding. We are only in our fifties but we can't see our grandchildren now and we are worried about driving in the future if my sight gets damaged.**

**My wife is also a recently diagnosed diabetic. This whole situation has made us realise how vulnerable we are and more scared about how we will go shopping or get to our appointments or see our grandchildren again.**

**This is very depressing for us and makes our children worried too. I don't know when I will get another appointment or if I should risk going to it."**

**"I was given an appointment the same day after feeling suicidal in Jan 2020 at ..... I was offered advice and sent home with a referral to the community team. Who I am yet to hear from it is now May 2020. There has been no follow up what so ever".**

## People waiting for screening services

In the early stages of lockdown most screening services were suspended, although some urgent screening services continued. People were told that if they had any symptoms they should contact their GP without delay.

People were not always clear what they should do at this time. For some people, the messages from different parts of the NHS were not the same.



For others, not knowing when things might start again and how the NHS would deal with the backlog worried them.

For people who were due screening appointments following earlier treatment, the delays meant they felt even more anxious.

**“We are being told that we shouldn't miss serious issues, and screening etc. But it seems we cannot go to the surgery, so how does that work? People need to know what is available for them.**

**Also my smear test has been put back months, and I'm sure the situation is the same for thousands of others.....”**



**"Having a pain in my breast radiating to my underarm and down to my elbow I became concerned. After a month I phoned the breast screening and was given an appointment. However the virus struck and it was cancelled /postponed.**

**Concerned I phoned for a GP appointment but was told they were not seeing anybody in surgery but the Dr was making phone consultations. In order to get a phone consultation I had to detail my problem to the receptionist for her to consult with the doctor as to if he would make the call.**

**However she returned to the call to inform Dr said no need for an appointment just take paracetamol!!!!!!  
End of March, condition remains!"**

"I was told after my last cervical screening test (February 2019) that I should have another test in 1 year. I telephoned to arrange but was told that their allocation of appointments were all taken and to phone back in a few weeks.

It is difficult enough as it is to try and time these appointments around time of month and also childcare so I did not expect that (+ the fact that it takes a lot of courage to go arrange and go to these appointments in the first place anyway!).

By the time I was able to try again to make an appointment, we were in lockdown due to Covid-19. It is constantly at the back of mind that something may have changed since my last smear test. My mum had Cervical cancer at the age of 29."

"My daughter who is 28 was diagnosed with bowel cancer in Feb 19, she was due to have an MRI scan in April but it was cancelled, this is causing anxiety for us all as a family, we would like to know when routine screening will resume?"

## **Lockdown easing and the re-introduction of NHS services**

**In June, the lockdown restrictions started to ease. People were able to meet outside as long as they kept socially distanced, and families and others were able to create support bubbles. Shops selling non essential goods could trade again and places to eat also began to re-open.**

**Shielding ended for many people, although not for people who were at most risk from the virus.**

**More NHS services started to be re-introduced across Wales. This included screening services, as well as some eye care and dental services.**

**Many services were provided in different ways, using technology.**

As the lockdown restrictions eased, we heard from people who were frustrated that they were still waiting and couldn't get the care they needed, even though they had heard that their services had re-started.

**"My husband's scan was cancelled and not rescheduled for 4 months. During this time, he had no face to face appointments with his consultant or any doctors at all - the cancer is back and has travelled to the lymph nodes in his neck. Had proper care been provided this could have been detected much earlier. I kept listening to the Health Minister say that the NHS was open for business.....I for one would say it wasn't".**

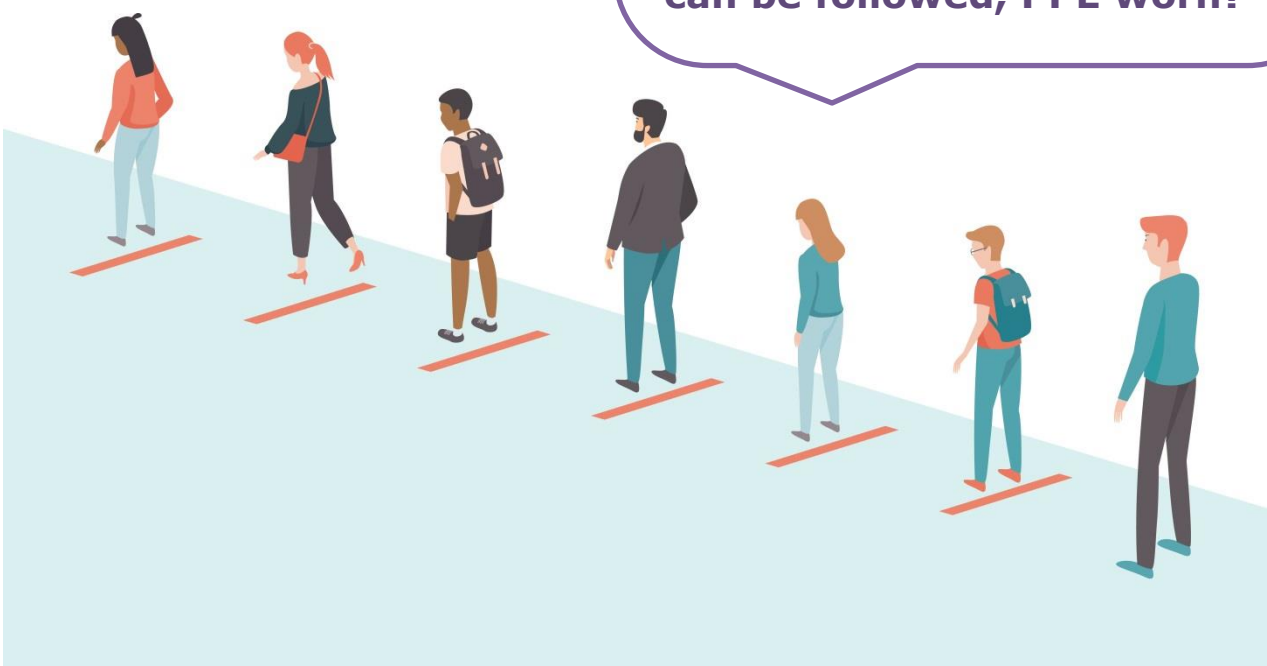


**"My GPs are still not doing cortisone injections. I am 63 years of age still working full time. I have worked every day through this virus but my knees are now so bad due to not being able to receive my cortisone injections I don't know how much longer I can go on for...."**

Lots of people felt that some NHS services were slow to re-open compared to other NHS services or wider services in the community, and didn't understand why this was happening.

**"Please resume normal health care for all, use social distancing and PPE, like everyone else has to. This is not fair."**

**"I needed to see the Dr regarding eczema, but seems too difficult not things are done over the phone rather than face to face. Other medical places are open, I don't know why the GPs still aren't when social distancing can be followed, PPE worn?"**



**"IVF treatment has been cancelled. Despite the HFEA and Government announcing that it can resume the WFI have still not even applied to reopen.**

**The updates have been limited and I have heard from other people going through the same. No timeline is being given and when you are battling infertility it's incredibly stressful. The impact that the delays are having on my mental health is substantial.**

**No support has been offered and it's been very mixed messages on social media. I understand that the health boards are delaying it but it needs to resume now. Other NHS clinics are open and have restarted seeing patients but WFI seem to be incredibly slow and are dragging their feet."**

When some services re-opened they were provided differently. Some people told us they wanted that to help them feel safe.

**"Screening appointment had to be cancelled March and still waiting for screening call (Breast)- Ophthalmology appointment had to be rearranged for August..... Make assurances that "business as usual" is safe - get the message out sooner and use the technology now available via video and phone".**

**"Proper PPE and safety can and should be in place for dentists to carry out these treatments safely, so that patients can receive the level of care they deserve and that the NHS promises to provide."**

We heard from others who felt that not being able to see healthcare staff face to face, or having to travel further to see their healthcare staff when services were reintroduced made things more difficult.

“People with long term conditions need regular face to face monitoring, especially as consultant appointments are now by phone. You need someone to actually see you. I had physio and 8 week post op all done by phone.

It is impossible to measure degrees of movement without physically seeing someone. I have had to choose my specially made shoes over the phone, not ideal.”





**“During the Coronavirus emergency my local surgery....has been closed. Every 10 weeks I receive a B12 injection, but at the beginning of the closure I was told my treatment was being suspended.**

**When it was eventually implemented I had to travel..... (having to catch 2 buses and a considerable walk - EACH WAY). I arrived at the stated time but was told I was half hour late (which I definitely was not) and had to go back home and come back in 2 days time again having to catch 2 buses each way and when you are not feeling well becomes exhaustive.**

**I contacted the Practice Manager regarding the reopening of the ... surgery but felt I was brushed off with the reply stating the reopening was under consideration for sometime in the future and to look at their website - which does not really tell you anything regarding the reopening”.**

Some people were relieved they didn't have to visit NHS premises but worried whether things would be missed if they were not seen face to face.

**"My diabetes care has mostly been phone based apart from blood tests. I have been a bit concerned that the usual hands on aspects have been missed I.e. Checking blood pressure, weight and foot care. I am still anxious about visiting the surgery but not sure what is worse."**

For lots of people facing continued delays, not knowing why or when their care might restart was particularly frustrating.

**"Whilst I understand that covid resulted in staff being relocated to work in covid wards I am left concerned that essential equipment and therapy stopped and has still not resumed. Patients have no idea when it will resume and in what form. Being offered a video call is no substitute for hands on help and therapy.**

**I would like to see a route map to get back to hands on therapy as it is not sufficient to say that it is no longer possible and Covid is likely to be with us all for years. The fear is that everything else will also stop until it is eradicated.**

**That cannot be acceptable..... communicate with users for the plan for their treatment/therapy/service to resume and in what period, what it will look like."**

**"..been waiting for an appointment since last October to see consultant about my knees had one letter to say they would contact me before lockdown Feb 2020, heard nothing contacted them to be told I was on a waiting list and it would be at least 6 months went into lockdown**

**- have heard nothing, contacted them last week and was told they are still not seeing anyone ..... I am now practically house bound being unable to walk any distance and in constant pain. Language used in letters need to be clear as to when I will be seen and any delay communicated with further dates."**

**"Communication, I understand why operations can't happen but keep me informed. The CMHT have no excuse really, all I need to do is speak to someone, the delay is bordering on cruel".**

**"Communication is key to help patients cope, i.e. reassurance that they remain on waiting lists and even if not known it would be great to know an approximation of when you may be seen or have treatment would make the wait a lot more bearable."**



**“Consultants and their teams should get in touch with people to explain why their illness isn’t important anymore. I’ve gone from having appointments every month to nearly 3 months without a single one.**

**My disease might be causing a lot more damage because it’s not being monitored when we know it is active. Also information on who to contact should you become unwell because I certainly don’t want to go to A&E as I’m in the shielding group... except I didn’t even get that letter until May!”**

During this time local health boards started to provide more general information about what was happening. This was found on their websites and in communities, explaining how local services were being provided during the pandemic, and when they were planning to re-introduce services.

Some local health boards are better than others letting people know what’s happening with their own care and with services more generally, including what the plans are moving forward.

As we moved into summer, when people started to be much more active in their communities and things were starting to feel as if they were getting back to some kind of normal, people started to get more frustrated that services seemed to be slow to restart.

Urgent care was being provided. NHS services were being re-introduced. Health boards were having to arrange services in different ways to separate patients receiving COVID care and those receiving non COVID care. However, many people didn’t know this was happening in their area.

People shared their worries that more and more people would become sick or get sicker with non COVID illnesses the longer it took to reintroduce services. Lots of people did not know what was happening with the field hospitals and whether these could be used to make a difference.

**"Use one hospital for non covid cases and one for covid cases so some planned operations could take place"**

**"The health service has not maintained its care of non covid patients and seems reluctant to restart.....Making services available again e.g.. checks in chronic conditions"**

**"I can understand operations were cancelled at the start but as soon as covid was under control all urgent ops should go ahead like other area, in particular children"**

**"It seems as though all other conditions, mine included (rheumatoid arthritis) have taken a back seat to the pandemic. More people are going to suffer because of lack of being able to get an appointment or treatment for non covid illnesses.**

**I suffer with rheumatoid arthritis and have not been able to see my rheumatologist or gp since March. I've been in pain and have been told to wait until the pandemic is over. I have a friend who was due to start therapy for trauma. I have another friend waiting for a cancer referral."**



## **People facing cancellations and further delays**

Some people told us their appointments that had been arranged during lockdown were cancelled at short notice. This caused real difficulties for them and their families.

**"I received a date for an operation .... so promptly self isolated, took Covid test etc. On the morning of the operation the ward rung asking me if I was ready to go in earlier which I was. Just as I was about to leave the house the surgeon rang and said the operation was cancelled due to a lack of staff.**

**I was told to continue to self isolate which I have done so. We are now 2 weeks on and despite ringing twice, still have no rescheduled date for my operation.**

**This means myself and three teenagers have already self isolated for 1 month for no apparent reason. We have no symptoms, are not shielding and have no date. As you can imagine my teenagers are not too pleased with this. When I ring or email and ask they say it's up to the surgeon who does lists when it's rescheduled.**

**I read online that in England it must be rescheduled within 28 days. The lady ..... told me this wasn't the case in Wales, but it seems ludicrous to just leave people in isolation for no reason and just have people hanging on.**

**The fracture has had a huge impact on my life as I was super active before and it also means that I can't work.  
....."**

People were even more concerned about cancellations if they didn't know why the cancellation had happened, or when they didn't feel the information they got was helpful.

**"Be honest with your communication. If you have to cancel an appt, don't send out generic letters which don't apply during a ... pandemic."**

**"I think keeping people informed as to what is happening would be good instead of giving appointments and the cancellation with no explanation."**

Many people still hadn't heard anything at all about when they might have an appointment. For people who were still waiting for appointments since lockdown started, we heard how this was making more and more of a difference to their lives, both physically and mentally.

**"I suffer with menorrhagia and suspected endometriosis. I have been put on numerous medications and nothing has stopped the pain. I get fobbed off each time I speak to a doctor, and I have been waiting for my referral to come back from the hospital since May 2020. My pain is getting worse. Nobody is taking me seriously"**



**"Since being referred 6 months ago by my GP to MCAS, I still have not been seen. I live in constant debilitating excruciating pain despite strong painkillers. My pain is increasing daily and limits capabilities greatly."**

**"My father has been waiting for a cat scan since March to see the cause of bowel obstruction. He is struggling physically and emotionally the wait."**

**My mother in law has been waiting over a year to see a geriatrician with Parkinson symptoms and now is deteriorating because of dementia symptoms with the shaking. Her appointments have been cancelled twice due to Covid."**

## People with worries about further delays leading up to winter

As we moved towards the autumn, we started to hear more concerns that people waiting for services may have to wait even longer if they have to be stopped again during winter.

**"Currently waiting for 2 urgent orthopaedic surgeries and am concerned that they may keep being postponed over the winter meaning not only months more in pain while waiting but also more long term damage being done in the meantime....."**

**"As a full-time carer, who is asthmatic and awaiting a cardio referral, I do feel anxious about the winter. .... We're still awaiting appointments that have been delayed due to Covid-19. We're hoping we'll get seen before we hit the winter period."**

**"I had a hip replacement beginning of this year and was due another 12/14 weeks later. Due to Covid I'm still waiting, I am very concerned about this I have been on sick from work for a year ready. I need to get this sorted before another break out and the usual winter illnesses.....A quick hip replacement so I can work and look after elderly parents"**



## Dealing with the backlog and planning for the future

As the pandemic continued to affect NHS care and treatment across Wales, people's concerns grew about the size of the backlog being created.

People worry that the NHS was struggling before, and want to know more about how it will catch up in the future. People want to be involved in planning for the future.

**"I can't see them catching up with the backlog unless plans are put in place. Inevitably, people will die of other illnesses, because the system was struggling before. It would be nice to see what plans are afoot to catch up with other health issues".**

**"I understand we are in a very difficult time, but in my professional opinion the surgery and other services offered by the Health Authority have been reduced by too much and you should be using your influence to encourage more face to face activity or we will find ourselves in another health pandemic caused by the backlog of undiagnosed illnesses during the current COVID-19 pandemic in the next 1 - 5 years."**

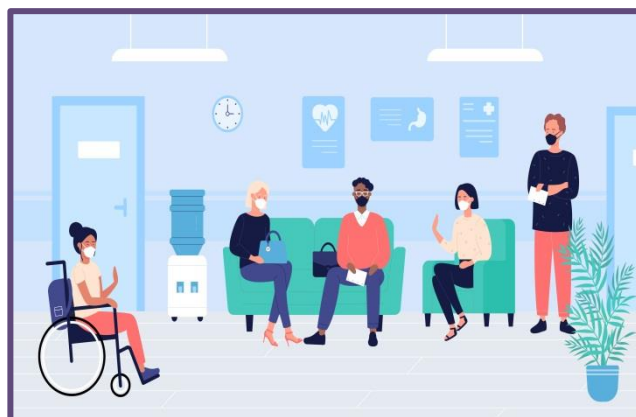
**"Liaise better with individual citizens, voluntary and council services to ensure solution are always co-produced and everyone is involved in planning, delivery and evaluation of our health service".**

## Reintroducing services at different times

CHCs know that there are differences across Wales in the way that services are being re-introduced.

We know that sometimes, this variation is because NHS staff may be unable to do their usual work because

they are needed more elsewhere or because of their own personal situation. It may be because NHS premises are not available to provide services in a safe way, or there may be other reasons.



If a certain kind of operation or treatment can be restarted in one area of Wales (or England), it doesn't make sense to people that it isn't available in another area, or if it takes much longer for people to be seen in one area than another.

People will feel this is unfair if no one explains the reason for this, and what is being done to make things better.

It is important that the different NHS bodies in Wales work together to make sure that decisions about restarting services get the balance right when thinking about the impact on people of waiting for treatment.

In November 2020, the Welsh Government started letting people know again about the numbers of people waiting for NHS care and treatment in Wales.

This will help make it easier for everyone to see where there are differences, to find out more and let people know why

there are differences, and to take action to make things fairer where this is needed.

## Learning from what we heard



Throughout the pandemic, CHCs have heard the grateful thanks from people in Wales for everything health and care staff have done and continue to do to care for people when they are ill. We hope the feedback people have shared helps NHS staff and others to recognise and value what has worked well for people so far.

We also heard the heartbreaking and devastating impact on many people whose care and treatment has been delayed because of the pandemic. We heard the worries people have about becoming ill in the future because vital early detection has not always been possible.

We heard the difference it makes to people when they know and understand what is happening with their care and treatment, and where they can go to get further advice and support. This makes any delay easier to manage.

When this doesn't happen, people get more anxious and concerned – particularly if they don't know the reasons why or when they might be seen. They worry about being forgotten in the system, and often don't want to bother the NHS to find out at such a busy time.

**NHS bodies in Wales** need to respond to the worries people have shared with us by making sure:

- healthcare staff keep in regular touch with people waiting for care and treatment. This will help them know what is happening, how long they might need to wait, the reasons for the delay and what the delay might mean for them in the longer term
- people waiting for care and treatment know how to get advice and support while they are waiting
- healthcare staff involve people in discussions about the benefits and risks of treatment during the pandemic. This will help people feel involved in the decisions being made and that they have control over their own lives through shared decision making
- they explain clearly and simply when changes need to be made to the way services are provided during the pandemic, and what this means for people attending for care and treatment
- they provide up to date, clear and simple information about how local NHS services have changed during the pandemic, and what the plans are to reintroduce services
- they reach more people who may not be able to find things out by looking on-line. Not everyone has or is able to use a smartphone, tablet or computer. Accessible, up to date information should also be shared in other ways through community networks and groups.







The **Welsh Government** needs to make sure:

- healthcare services in Wales get things right in balancing the harm caused by or as a result of the coronavirus pandemic
- all NHS services for people living in Wales are reintroduced as soon as it is safe to do so, taking action to identify and address any unnecessary differences across Wales.

People living in Wales know and understand there are big challenges facing the NHS in the years ahead as it tackles the harm caused by the coronavirus pandemic. It will be as important as ever that it does so by involving people in developing its plans and designing its services for the future.

# Thanks

We thank everyone who took the time to share their views and experiences with us about their healthcare services and to share their ideas.

We thank the healthcare staff who are working so hard to care for people and their loved ones during the pandemic.

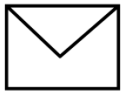
We hope the feedback people have taken time to share influences healthcare services to recognise and value what they do well – and take action where they need to as quickly as they can to make things better.

# Feedback

We'd love to hear what you think about this publication, and any suggestions about how we could have improved it, so we can use this to make our future work better.



# Contact us



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